FINAL EVALUATION OF THE USAID COOPERATIVE AGREEMENT (1993-1998) WITH AVSC INTERNATIONAL

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by

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The observations, conclusions, and recommendations set forth in this document are those of the authors alone and do not represent the views or opinions of POPTECH, BHM International, The Futures

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Finally, we thank and acknowledge the support of USAID. Many Office of Population staff met with the team to consider the future contributions which AVSC should make to support the Office of Population's and USAID missions' Strategic Objectives. Also, many mission staffs met with the team: USAID/Kenya, REDSO/ESA, USAID/India, and USAID/Nepal. Another seventeen missions responded to the Office of Population's e-mail survey. The team has tried to incorporate the thoughts of the mission staffs into this evaluation by presenting the majority opinion on critical questions regarding AVSC's performance, collaboration, leadership, and mandate.

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APPENDICES

LIST OF ABBREVIATIONS

CA	Cooperating Agency
CAR	Central Asian Republics
CFA	Client flow analysis
CHAK	Christian Health Association of Kenya
COPE	Client-oriented, provider-efficient services
CTU	Contraceptive Technology Update
D&C	Dilation and curettage
EOC	Emergency obstetrical care
FPAK	Family Planning Association of Kenya
FPAN	Family Planning Association of Nepal
FHI	Family Health International
G&A	General & Administrative
G/PHN/POP	Office of Population, Center for Population, Health and Global Programs
HPV	Human papilloma virus
IBHD	Insertion before hospital discharge
ICPD	International Conference on Population and Development
IMIS	Integrated management information system
IMSS	Mexican Social Security Institute/Instituto Mexicano de
INTRAH	Program for International Training in Health
IPPF	International Planned Parenthood Federation
IPPI	Immediately postplacental insertion
JHPIEGO	Johns Hopkins Program for International Education in
JHU/PCS	Johns Hopkins University/Population Communication
LGU	Local government units
MAP	Men as Partners
MAQ	Maximizing access and quality of care
MOH	Ministry of Health
MVA	Manual vacuum aspiration
NGO	Non-governmental organization
NSV	No-scalpel vasectomy
OB/GYN	Obstetrician/gynecologist (obstetrics/gynecology)
OJT	On-the-job training
OP	Office of Procurement (USAID)

OR	Operations research
PAC	Postabortion care
PACD	Project assistance completion date
PIAC	Post-incomplete abortion care
PIO	Project implementation order
POPTECH	Population Technical Assistance Project
PPIUD	Postpartum intrauterine device
PRIME	Primary Providers' Training and Education in Reproductive
QIAC	Quality Improvement Assessment Checklist
QOC	Quality of care
REDSO/ESA	Regional Economic Development Support Office/East and Southern Africa
RTI	Reproductive tract infection
SDP	Service delivery points
SIL	Squamous intraepithelial lesion
SOW	Scope of Work
UMATI	Tanzania's Family Planning Organization/Uzazi Na Malezi
VSC	Voluntary surgical contraception
WHO	World Health Organization

EXECUTIVE SUMMARY

This report presents the U.S. Agency for International Development (USAID)-funded evaluation of the 1993 to 1998 Cooperative Agreement between AVSC International and USAID. The purpose of this agreement is to

> introduce and expand voluntary surgical contraception and other long-term methods. The key elements include the following: 1) medical quality assurance, 2) voluntarism and informed choice, 3) client-centered systems, 4) service-based training, 5) vasectomy and male involvement in family planning, 6) postpartum and postabortion family planning services, 7) sustainable and cost-effective services, and 8) evaluation and research.

USAID has obligated $72 million to this Cooperative Agreement through December 31, 1996; AVSC has expended $58 million through March 31, 1997. Core funds comprise approximately 20 to 25 percent of the total budget; in 1997, core funds comprise 4.5 million of a $28 million budget. In 1997, country programs comprise 76 percent of this total. USAID missions state that AVSC is a key contributor to their Strategic Objectives and express the need for continued assistance from AVSC in expanding and improving the quality of permanent and long-term family planning methods.

AVSC International

AVSC International, formerly the Association for Voluntary Surgical Contraception, is a nonprofit organization that works to improve reproductive health services worldwide. Established in 1943, AVSC was founded to make voluntary sterilization services more widely available and accessible in the United States. In 1971, AVSC began working in the developing world and received its first funding from USAID the following year. In the 1980s, AVSC broadened its focus to encompass the full range of long-term family planning methods, and in the 1990s, following the International Conference on Population and Development (ICPD) in Cairo, it broadened its mission further to encompass reproductive health.

This Evaluation

USAID noted in the evaluation Scope of Work (SOW): "This evaluation will provide important information for the development of a follow-on program. One-half of the evaluation exercise should focus on past accomplishments and one-half on future needs of USAID and new and emerging issues." In fall 1997, a four-person team began the evaluation with a USAID briefing, traveled to New York for four days of meetings with AVSC, and then spent 17 days working in Kenya, India, and Nepal. The team viewed clinical service delivery in 16 service delivery sites, observed 2 training events, and interviewed 12 host-country counterpart institutions. Also, the team interviewed staff from key collaborating agencies and read materials supplied by USAID, AVSC, and counterparts.

Particularly important to the evaluation were the thoughts and opinions of USAID field missions. USAID's Office of Population (G/PHN/POP) sent an e-mail to relevant missions soliciting input on AVSC's performance and on their priorities and mandate for the follow-on Cooperative Agreement, and held phone and in-person interviews with other mission staff. Altogether, the team received input from e-mail responses, phone calls, or interviews with 21 USAID missions or offices, and interviews with staff members of various G/PHN/POP divisions.

Accomplishments of this Cooperative Agreement

AVSC's fieldwork through this Cooperative Agreement continues to be focused on surgical contraception or, as it is commonly referred to, long-term and permanent methods? female sterilization, vasectomy, NORPLANT?, and postpartum IUDS. AVSC has achieved all 14 of the Cooperative Agreement indicators that deal with aspects of service delivery, such as counseling, training, and research, and has provided leadership in the field through publications and presentations at professional meetings. For example, between 1993 and 1997, AVSC worked with 28 national programs to improve client counseling, with 18 countries on male involvement programs, with 37 countries to provide technical assistance for installing or improving national training programs for clinic-based methods, with 29 countries on client-centered service management programs, and with 35 countries to reach postpartum and postabortion women. AVSC produced or revised numerous quality assurance guidelines or references, produced professional and journal publications, undertook client-focused research, delivered papers, and provided technical assistance in over 40 countries. Also, AVSC staff published 37 papers in a variety of journals and books. AVSC introduced its quality improvement approaches in more than 25 countries, particularly in East and Southern Africa.

AVSC has provided highly appreciated support to the Office of Population and the CA community through participation in USAID task forces and committees. AVSC produced a report on the "metering restrictions" of USAID population funds and how these provisions

negatively affect program management and services. Furthermore, AVSC's work on free and informed choice is also particularly noteworthy. AVSC demonstrated global leadership in the mid-1990's when concerns were raised about the safety, effectiveness, and consent problems surrounding quinacrine. AVSC held a meeting of experts to discuss these issues and published a working paper in July 1994, summarizing the opinions and recommendations made at the meeting.

AVSC makes contributions to the Population, Health and Nutrition (PHN) Center's Strategic Objectives, many of which fall under *SO 1*, "*Increased use of voluntary practices by women and men that contribute to fertility reduction*," and its four program results. But because AVSC indicators are all at the process-level, they do not enable USAID or an external evaluation to assess the extent of AVSC's contribution to these results. USAID missions have also developed Strategic Objectives. The Office of Population's e-mail asked missions if they considered AVSC's program an important contributor to achieving their Strategic Objectives and in what ways AVSC was called to contribute. The missions responded positively; the vast majority of missions spoke of AVSC's critical role in expanding access to and quality of clinical and surgical contraception.

In some countries, AVSC contributes through persuasion with regard to policy issues. For example, AVSC has developed a credible voice on clinical quality and safety and in Kenya has assisted in developing policy guidelines on reproductive health. In Nepal, AVSC helped the government develop the reproductive health policy environment by creating a matrix that revealed gaps and inconsistencies in policy and highlighted conflicts between policy and program priorities. Also, AVSC is working behind the scenes in Nepal to encourage the government to reconsider its current program of incentives and rewards, including financial incentives for providers based on number of sterilizations performed.

AVSC-Assisted Service Delivery

During this Cooperative Agreement, AVSC has worked in or charged expenses to over 62 countries, including countries where AVSC has "comprehensive country programs," "limited programs," including a number of countries in which AVSC has implemented tiny activities. In fiscal year 1997, AVSC had Cooperative Agreement budgets for 27 countries, including 13 countries with budgets exceeding $500,000. AVSC's work covers a broad range of activities, including providing subtle support for policy changes, developing reproductive health guidelines, providing technical assistance to renovate and upgrade clinical facilities, providing clinical training, and introducing quality improvement approaches.

In previous Cooperative Agreements, AVSC worked with host-country institutions on a project basis, funding clinical service delivery in a specific institution by providing funds for utilities, staff, equipment, supplies, and travel. In return, the institution shared its service statistics with AVSC. However, over the past five years, AVSC has moved to a technical assistance and program approach; consequently, there is a weaker basis for obtaining service statistics, and AVSC has only limited and partial data on service utilization in the institutions it has assisted. Nevertheless, individual USAID missions indicate that AVSC's work has been critical in expanding access and increasing utilization.

Female and male sterilization is at the core of the Cooperative Agreement and is a focus of AVSC's efforts in almost all countries. Since its inception, AVSC has been a recognized leader in sterilization training. AVSC perfected and disseminated clinical training in minilaparotomy with local anesthesia and provides technical assistance on supervision and medical monitoring of the procedure. Many missions wrote of AVSC's important contributions to improving access to and quality of sterilization services through the development of guidelines or protocols, training and technical assistance, policy reform, medical monitoring, and counseling.

However, continued work on improving the quality of the sterilization procedure appears warranted. Some women undergoing minilaparotomy sterilization in developing countries seem to be experiencing greater pain than their U.S. counterparts who have access to drugs for conscious sedation not generally available in minilaparotomy programs. Although it is impossible to generalize about every country doing minilaparotomy with local anesthesia, a similar concern about pain relief was expressed during the 1991 midterm evaluation of AVSC. In addition, unsolicited corroborations of this perioperative issue have been expressed by three consultants to international family planning programs who have observed minilaparotomy with local anesthesia procedures in various countries during the past five years.

AVSC is one of USAID's strongest CAs in its customer orientation and client focus. Clients are at the center of AVSC's programming framework and customer satisfaction has been a focus of AVSC's research and approaches to quality improvement. However, AVSC has not studied clients' experiences with pain relief during and immediately after minilaparotomy and how this affects client satisfaction. Although a 1995 AVSC-commissioned survey asked 500 men and 500 women in Nepal about their satisfaction with their voluntary surgical contraception (VSC) services, the study did not evaluate the degree of discomfort or pain experienced, nor did it evaluate pain relief during and immediately after the operation. Furthermore, there has not been an assessment of pain to determine how such feelings might affect client satisfaction and referral. Conscious sedation may increase the acceptance of tubectomy. This could be verified by operations research conducted in one or more countries with mature, stable minilaparotomy with local anesthesia programs.

Despite the efforts of AVSC and other CAs, male sterilization has not been widely used in most developing countries. The latest available data indicates that global use has not increased despite the fact that it is an easier procedure than female sterilization, a technically superior method of vasectomy is available, and there have been efforts at promotion and supply.

In 1988, the worldwide use of vasectomy was 5 percent while the use of female sterilization was 13 percent. The last available data from 1994 shows that the global percentage of current users (based on couples with the woman of reproductive age) was still 5 percent for vasectomy and 17 percent for female sterilization. In less developed countries, excluding China, these figures were 3 percent and 14 percent. In sub-Saharan Africa, use of vasectomy was only .1 percent compared to 1 percent for female sterilization.

AVSC reports that, in the AVSC-assisted institutions for which it has service statistics, 70,000 vasectomies occurred in 29 countries over a four-year period. Mexico accounted for the majority of these cases. Among many reasons for the relative failure of no-scalpel vasectomies (NSV) in most countries are the lack of leadership, the lack of a long-term IEC effort, the absence of facilities that attract men, as well as inadequate infrastructure, equipment, and supplies.

AVSC believes emphasizing male reproductive health is more productive than emphasizing NSV alone. AVSC's Men as Partners (MAP) program has three goals: (1) increase men's awareness and prevention of STDs; (2) increase access to male methods of contraception; and (3) increase men's support of their partners' reproductive choices. The MAP program has conducted a workshop; produced pamphlets, posters, and several videos; and updated training materials. However, at the grassroots level in two of the three countries visited (Kenya and India), little excitement and energy is being devoted to MAP compared to the effort devoted to more conventional activities in support of female sterilization, IUDs, NORPLANT, and quality management tools. In contrast, Nepal has a longstanding, increasingly successful MAP program. This success is due in part to the skill and enthusiasm of one highly regarded, long-time practitioner of NSV, whose reputation continues to facilitate its acceptance although he no longer practices regularly. This situation shows the importance of leadership to the success of a program.

Since 1993, AVSC has actively organized activities to protect women from severe complications resulting from incomplete abortion, including delayed treatment in hospital, infection, and excess blood loss, and to coordinate timely and efficient family planning opportunities after abortion. With regard to Kenya, one of eight countries in which AVSC has initiated postabortion care (PAC) activities, the team concluded that PAC activities should be part of core activities in the follow-on Cooperative Agreement. The PAC initiative is a major contribution to women's health.

Delayed treatment of abortion complications and neglected infection, and excessive bleeding from these complications contribute significantly to maternal deaths. Moreover, prompt treatment of these complications will decrease the use of valuable hospital facilities and the need for antibiotics. When PAC is fully implemented, septic abortion cases will become rare hospital admissions, rather than filling many hospital beds.

AVSC's experience with all aspects of sterilization services has enabled it to transfer counseling, surgical, and infection prevention principles into other areas of reproductive health. All the inpatient and outpatient units with which AVSC has been associated are, presumably, safer places for the treatment of women because of the intensive infection training carried out over the past ten years. Furthermore, in all its activities, AVSC emphasizes the importance of STDs and condom use not only for contraception, but also for protection against the spread of disease.

Capacity Building for High-Quality and Sustainable Services

AVSC's approach to quality assurance has evolved significantly during the current Cooperative Agreement with USAID. As AVSC moved from a project to program focus, it became concerned with sustainability and its staff's ability to monitor quality in all worksites. Moreover, in the process of examining how to provide quality family planning services, AVSC often found clients' perspectives were missing; family planning services were fragmented and vertical; training was inappropriate, narrowly focused, or unsupported; and supervision often took an auditing rather than supportive approach. As a result of this analysis, AVSC invested in tools and approaches, still being refined, to address specific service delivery needs:

- Problem identification and problem solving at the service delivery site;
- Empowerment for and ownership of the quality improvement process leading to sustainable improvement of supervision, including reconnecting supervision and training;
- Technical competence and quality assurance; and
- Access to services and links between services.

Key among the tools and approaches are client-oriented, provider-efficient services (COPE); whole-site training; facilitative supervision; and In-Reach and on-the-job (OJT) training. In COPE, facilitative supervision, and OJT, AVSC has developed and marketed simple, common-sense tools to improve performance and service delivery. Many other CAs are working in quality

improvement and assurance and have developed similar instruments, exercises, and tools to improve services, but COPE is the only quality tool that is also a self-assessment tool used with clinic providers to improve service delivery. COPE is also noteworthy because it incorporates client feedback to improve service. Facilitative supervision, AVSC's term for good supervision, emphasizes the obvious; good supervision is essential to achieving consistently high performance. More good supervision is urgently needed, and AVSC should be commended for recognizing the importance of good supervision and making it a cornerstone of its program. Providers who participated in AVSC's facilitative approach attest to the difference in their outlook and behavior.

In addition, AVSC has developed several useful medical monitoring tools to objectively and systematically observe procedures and identify problems. These instruments encourage a systematic and objective observation of clinical skills and practices to ensure safe patient care of good quality. They are designed to assess NORPLANT, vasectomy, minilaparotomy, and infection control and asepsis practices and procedures and to help ensure standardization of quality practices for specific procedures.

In the last Cooperative Agreement, sterilization training was an important activity. More recently, AVSC has moved into other training areas in clinical methods and procedures, including NORPLANT, DMPA, postpartum IUD, postabortion care, infection prevention, contraceptive technology updates, and counseling. With the development of its quality approaches, AVSC has more recently expanded training to include quality of care (QOC), medical quality assurance, and supervision. It has also developed new training methodologies, notably on-the-job training, which it hopes is more effective and sustainable than traditional, centralized training.

Cooperative Agreement Management and Organization

AVSC staff described their organization as one that is constantly remaking itself. This process has been intense over the past few years, driven by a number of factors: the ICPD, a new president, and changes in USAID's funding mechanism. Changes have also occurred in response to the last evaluation and to AVSC staff input at 1994 and 1995 strategic planning exercises. AVSC has a new mission, new institutional goals, a new program structure, and an excellent new finance system. The decentralized program structure looks good and it appears that sufficient authority has been delegated to field offices, enabling AVSC to better serve its major client: USAID missions. However, AVSC should review its field recruitment and hiring procedures; one-third of the missions who provided input into this evaluation indicated that the country offices are, or had been until recently, weak in managerial or technical (clinical) skills. Five of the 13 missions currently investing over $500,000 annually in AVSC's programs identified current weaknesses in AVSC's field office staffing.

USAID has made changes, and AVSC has been responsive to those changes. Of importance is AVSC's concerted effort to diversify its funding base. In 1992, USAID funds represented 90 percent of AVSC's total income of $17.9 million; other income totaled $1.8 million. Although annual income from USAID fluctuated between $14.5 and $21.3 million since this Cooperative Agreement began, other income has risen steadily. In 1997, non-USAID income was 16 percent of AVSC's total income, double that of 1992 in actual dollars. AVSC credits USAID core funding with its ability to leverage other funds and, conversely, AVSC's non-USAID income helps USAID. AVSC is able to use non-USAID funds for new areas not yet funded by USAID, such as early work in postabortion care, or for work in countries not yet funded by USAID, such as Vietnam.

AVSC collaboraters excellently with USAID and other CAs. Where its field mandates have overlapped with those of other CAs, AVSC has worked constructively to minimize overlap and duplication.

MAJOR CONCLUSIONS AND RECOMMENDATIONS

The following section summarizes the major conclusions and recommendations of this evaluation and provides a list of recommended results for the follow-on Cooperative Agreement. This section of the report is organized differently than the body of the report and the recommendations are numbered differently. Therefore, the recommendations are cross-referenced, with the corresponding recommendation given in parentheses after the recommendation.

Mandate for the Follow-On Cooperative Agreement

Conclusions

AVSC occupies a unique niche among USAID-funded CAs. USAID and other CAs recognize AVSC as a leader and trailblazer in promoting access to and quality of long-term and permanent family planning methods at tertiary and secondary service delivery points. USAID, other CAs, and AVSC itself want AVSC to continue its leadership role. A definition of leadership that best captures the hopes USAID and other CAs have for AVSC is "leadership means influencing the community to face its problems....Progress on problems is the measure of leadership; leaders mobilize people to face problems, and communities make progress on problems because leaders challenge them and help them do so" (ref. 1994). The figure on the following page illustrates the potential results of such leadership.

To achieve their Strategic Objectives and results, USAID's Global Bureau and mission staff identified a continuing need for a focused CA to lead efforts to address problems of unmet need for high-quality surgical contraception, including activities to promote access, improve quality, increase utilization, and understand national and global trends. The relative failure of NSV is a particular problem.

The majority of USAID respondents did not favor broadening AVSC's mandate to address broader USAID Strategic Objectives. They cited several reasons for continuing a mandate focused on clinical and surgical contraception. A principal reason cited by various missions was that expanding access to and quality of clinical and surgical contraception was such a large job that the addition of other activities might weaken AVSC's efforts toward that end. Other missions wrote or spoke about USAID's limited resources; these missions saw an expanded AVSC mandate as overlapping and inefficient.

Recommendation

1. AVSC's mandate in the follow-on Cooperative Agreement should have, as its core, promoting access to and quality of long-term and permanent contraceptive methods. (Recommendation #20 in report)

Figure 1

More Attention to NSV Expansion

AVSC should continue to intensively develop the MAP initiative, including most specifically the expansion of NSV. Efforts to promote NSV must not be allowed to languish as other projects are started. There are many elements to a successful NSV program; consciousness-raising and training are essential, but as the team observed, so too are infrastructure, equipment, and supplies. Leadership is particularly vital, as seen in countries as disparate as Brazil, Colombia, Turkey, and Pakistan, which have had small but successful programs seemingly based primarily on the powerful leadership of an enthusiastic vasectomist who vigorously and devotedly generates interest and provides quality personal services.

Recommendation

2. In every country where AVSC, in collaboration with USAID and host-country counterparts, decides it is important to improve access to and availability of vasectomy services, AVSC should review all the components of planning and managing NSV services to ensure each component functions well. A written plan should identify CAs' responsibilities to lead and facilitate various components; identify any gaps or weaknesses, whether leadership, IEC, provider competence, infrastructure or supplies; and specify activities to address those gaps or weaknesses. (Recommendation #4)

Better Perioperative Pain Management for Minilaparotomy with Local Anesthesia

Conclusions

Despite the many changes that it has made in voluntary surgical contraception (VSC) services over the past 17 years, AVSC has apparently not changed the analgesia regimen for minilaparotomies. Over the past 10 years, however, new drugs, synthetic opioids, and short-acting benzodiazepines, have become available and accessible as less expensive generic brands. These products can now be given intravenously and can provide excellent pain relief, including a degree of amnesia, for the operation. These products are currently the standard of care in developed countries to support local anesthesia in procedures that enter the abdominal cavity, such as minilaparotomies.

Recommendation

3. As part of USAID and AVSC's continuing efforts to improve quality of care,

AVSC should consult with an expert in obstetrics/gynecology (OB/GYN) analgesia to consider better perioperative pain management for minilaparotomy with local anesthesia. (Recommendation #2)

Postabortion Care

Conclusion

PAC is a natural addition to AVSC's core USAID-funded activities, a service that builds on AVSC's competencies and has the potential to improve maternal health and reduce hospital costs.

Recommendation

4. AVSC should add PAC activities to their clinic-based activities whenever possible and appropriate. As AVSC and other CAs expand these services, they should give close attention to all service components in the same manner recommended for vasectomy. (Recommendation #5)

More Partnering with Other CAs in Clinical and Operations Research

Conclusions

AVSC appropriately undertakes research, usually in collaboration with other CAs with specific research mandates, when there are specific issues related to AVSC's unique niche in clinic-based service delivery. AVSC, Family Health International (FHI), and Mexican colleagues have recently reported the findings of a preliminary study to determine the time it takes sperm counts to diminish to the point of infertility and azoospermia following apparently successful NSV. The long period of time to azoospermia in a significant number of men following NSV suggests that a larger and extended corroborative study is necessary.

Operations research could provide needed answers to several current clinical problems and questions raised throughout this report on NSV and PAC.

Recommendations

5. AVSC should collaborate on important NSV research including analyzing vasectomy failures in countries such as Mexico and Nepal where large-scale

programs exist, and it should facilitate continued study of sperm formation and delivery after NSV, in collaboration with FHI and in consultation with experts in human sperm physiology. (Recommendation #16)

6. AVSC should undertake operations research in the following two areas:

   - **Vasectomy**: Study the variables affecting NSV acceptance, the post-training performance and needs of NSV providers, and the ways in which the NSV technique is absorbed by seasoned clinicians in developing countries.

   - **PAC**: Study the value of PAC in its care of incomplete and potential septic abortions, its ability to minimize blood loss often associated with neglectful or delayed care, and the role paramedics can play in PAC. (Recommendation #17)

Better Evaluation of AVSC's Entire Program

Conclusions

The past two evaluations of AVSC's prior Cooperative Agreements found that AVSC's evaluation was weak and needed to be strengthened. This relative weakness continues; AVSC country evaluations serve more of a monitoring function than an evaluating function to gauge the impact of specific strategies and interventions. Currently, the Cooperative Agreement has only process indicators, with no impact, outcome, or service statistic data requirement. Numerous USAID missions commented that AVSC had paid insufficient attention to training follow-up and evaluation.

However, the team believes that AVSC is determined, funds permitting, to build a strong evaluation component into their program. In New York and in the field, AVSC enthusiastically participated with this evaluation team to develop results and indicators for the follow-on Cooperative Agreement. When pressed by the team to be sure they wanted to be measured and held accountable at the proposed outcome levels, field staff readily agreed. Moreover, in the new corporate team structure AVSC evaluation staff will be able to work with program staff early in the planning process to incorporate evaluation into programming and training activities.

It is important to evaluate on-the-job training. In this methodology, on-site practitioners are usually used as trainers; off-site supervisors, qualified to certify the trainee, then observe the

trainee to certify the transfer of skills. In Kenya, the team observed that off-site supervisors are often busy practitioners who work in high-volume, resource-poor institutions with myriad manpower, supply, and equipment shortages. In small clinics, the number of specific procedures may be so sporadic that training takes place over long stretches of time during which staff has changed. Conversely, in clinics where many procedures take place, busy practitioners may not have time to review the didactic and theoretical knowledge needed for effective skills transfer. In Kenya, many trainees urgently need to be trained in specific procedures, but on-site training is time consuming and probably not the best strategy for addressing these backlogs.

Recommendations

7. AVSC and USAID should make a higher-level investment in AVSC's evaluation of its programs. (Recommendation #19)

8. AVSC should strengthen its evaluation by developing results and indicators for measuring achievements that report service statistics, impact, and outcome data where possible. (See Chapter 9)

9. AVSC should devote resources to evaluate training impact in a more systematic and routine manner. OJT should receive special attention to verify the quality of service rendered by providers and the volume of service providers trained in this approach. AVSC should develop curricula for transferring specific knowledge and skills that are consistent with an OJT training strategy and should review the implementation of OJT in the Kenyan program (and in other countries) to ensure that OJT guides, curricula, and skills competency training are appropriate, observed, and systematically applied. A special evaluation study should compare the effects and outcomes of this approach versus more traditional models. AVSC should be systematic in its use of on-site training. Training strategies to address given training needs should be carefully selected, with central training considered as an option where appropriate. (Recommendation #10)

10. AVSC should work with the Population Council's Operations Research Project (FRONTIERS) and FHI to design and conduct a rigorous evaluation of the key tools in the quality improvement package? COPE, facilitative supervision, and OJT. The study should examine changes in providers' attitudes and behavior, client satisfaction, quality, and service utilization. (Recommendation #8)

Ensuring that Health Resource Management Tools are Tested in the Public Sector Prior to

Scale Up

Conclusions

AVSC has packaged, documented, and marketed their quality improvement approaches well, and now, before scale-up, is the time to rigorously evaluate these approaches. To date, evaluations on COPE and facilitative supervision have been process-oriented, qualitative, and anecdotal. With COPE, AVSC has based most of its findings on post-COPE interviews with providers and, in some cases, clients. More work is needed to objectively and verifiably measure changes in providers' attitudes or behaviors, client satisfaction, and service statistics at facilities that have used COPE to better show how and when these are effective approaches to improve quality and increase use of reproductive health services in large public sector systems.

To evaluate facilitative supervision, the newest of AVSC's quality improvement approaches, AVSC has relied on interviews with supervisors and their staffs. Although intuitively this approach makes sense in non-governmental organizations (NGO) where there is greater management control, more information is needed about the circumstances in which it is appropriate and effective in large under-funded, overwhelmed, public sector systems. Before several countries attempt to scale-up this approach to larger public sector systems, more rigorous evaluation should be conducted.

The purpose of these tools is to institutionalize quality. However, the team doubts that institutionalization (ownership or skills) has occurred at the larger Kenyan sites visited.

An AVSC internal discussion document on sustainability highlights the importance of ownership and reflects AVSC's search to define its role in promoting sustainability. It also acknowledges AVSC's need to develop and apply process indicators and benchmarks. The evaluation team urges AVSC to begin that work. At issue is the quality of training, monitoring, and follow-up that will occur when AVSC has "scaled-up" with public sector institutions by delegating greater responsibilities to local counterparts who are already overwhelmed by myriad tasks and responsibilities, as well as a lack of resources. COPE, like other continuous quality improvement tools, demands time and commitment from management and staff. COPE facilitation is a complex skill that takes time and practice to achieve competency. Institutionalization, which AVSC intends, means that the newly introduced problem-solving approaches recently applied to issues under AVSC's facilitation, can be applied to new and potential problems on a continuing basis without AVSC's facilitation.

Recommendations

11. AVSC should develop indicators and benchmarks on the institutionalization of COPE and facilitative supervision, including institutionalization of skills and commitment. AVSC staff should cofacilitate COPE and facilitative supervision sessions, training and coaching counterpart staff until they are competent to facilitate on their own. (Recommendation #7)

12. AVSC should design pilot projects with intensive and rigorous evaluations of COPE and facilitative supervision in countries such as Tanzania, Kenya, and India. These studies should examine in an objective and verifiable manner the impact of the approach on quality of services and method mix. Only then should AVSC scale-up the model to wider geographical areas. (Recommendation #9)

Management and Organization

Conclusion

AVSC has invested great effort and achieved considerable success in developing its planning, management, and structure. However, the one important system that has yet to be revamped is human resources. It is important to review that system, particularly procedures for hiring and recruiting. Mission comments on inadequate technical and managerial skills should be a rarity in comprehensive programs.

Recommendation

13. AVSC should review its recruitment and hiring policies to ensure that: (1) all new New York-based staff in mid- and senior-level program positions have field experience in developing countries and (2) comprehensive country programs are adequately staffed with professionals with technical and managerial skills. (Recommendation #1)

Other Recommendations

AVSC should consider collaborating with like-minded people and organizations to hold an international meeting on Men as Partners. Contributions for this meeting would be solicited from a broad range of interests: psychology, anthropology, and ethics and religion, as well from those in the forefront of service delivery. (Recommendation #3)

The search for a new medical director should be international in scope. An ideal candidate would have clinical training in OB/GYN, experience in public health and/or an MPH, familiarity with clinical and operations research, interest in modern medical training and teaching modalities, and field experience in a developing country. (Recommendation #6)

14. AVSC should ensure that a counseling practicum observed by skilled and experienced counselors is a routine part of counseling training. AVSC should ensure that a follow-up system is in place to continue to work with recent counseling trainees, observing their skills in client counseling sessions to reinforce and build their skills. (Recommendation #15)

15. AVSC should encourage the use of the medical monitoring tools by "facilitative supervisors" to ensure quality, systematization, and standardization in skills transfer and application. (Recommendation #11)

16. USAID and AVSC should examine ways to provide missions with more frequent, routine, and detailed financial information on field support funds. Missions should receive quarterly expenditure and pipeline reports. (Recommendation #1)

Recommended Results in the Follow-On Cooperative Agreement

1. In countries with significant AVSC/Cooperative Agreement investment, women and men are better able to space and limit family size using clinical or surgical methods.

2. In selected health facilities where AVSC has invested significant capacity-building resources to treat postabortion complications and to provide counseling, education, and follow-up to those clients, deaths from septic abortion and hemorrhage have decreased.

3. In countries with significant AVSC/Cooperative Agreement investment, there is increased availability of and access to high-quality clinical family planning services (long-acting and permanent methods) and to other selected, closely related reproductive health services, particularly PAC.

4. At AVSC-facilitated institutions, there is increased client satisfaction among those women and men who chose to use long-acting and permanent family planning methods and among those who chose to use other closely related reproductive

health services.

5. Within selected AVSC-facilitated, host-country institutions where AVSC has made a large investment, behavioral change in RH providers has resulted in improved client focus and customer satisfaction.

6. Among AVSC-facilitated, host-country institutions, there is an increased organizational capacity for planning, managing, and evaluating clinic-based family planning and other closely related reproductive health services.

7. In countries with relatively limited AVSC/Cooperative Agreement funds (in contrast to comprehensive programs), AVSC provided inputs to promote the national RH program in response to USAID's requests.

8. As a result of AVSC's vision and leadership, global- and national- level clinical RH techniques have improved, resulting in safer and more effective RH services.

9. As a result of AVSC's vision and leadership, additional funds? beyond those provided to AVSC by USAID in this Cooperative Agreement? have been invested in new clinical family planning and other closely related RH services, techniques, and products that meet client needs for safe and effective service delivery.

10. As a result of AVSC's vision and leadership, there is greater use of vasectomy.

1. INTRODUCTION

1.1 Background

AVSC International, formerly the Association for Voluntary Surgical Contraception, is a nonprofit organization that works to improve reproductive health services worldwide. AVSC was established in 1943 to make voluntary sterilization services more widely available and accessible in the United States. Originally involved primarily in outpatient male sterilization, AVSC contributed substantially to changes in the legal, professional, and public climate that led to sterilization becoming the most widely used family planning method in the United States. In 1971, AVSC began working in the developing world and received its first funding from the U.S. Agency for International Development (USAID) the following year. In the 1980s, AVSC broadened its focus to encompass the full range of long-term family planning methods, and in the 1990s, following the International Conference on Population and Development (ICPD) in Cairo, AVSC further broadened its mission to encompass reproductive health.

The current Cooperative Agreement, signed in 1993 following 20 years of continuous USAID funding, was developed after a 1992 AVSC strategic planning process. The purpose of this Cooperative Agreement is to "introduce and expand voluntary surgical contraception and other long-term methods. The key elements of the Cooperative Agreement include the following:

(1) Medical quality assurance,

(2) Voluntarism and informed choice,

(3) Client-centered systems,

(4) Service-based training,

(5) Vasectomy and male involvement in family planning,

(6) Postpartum and postabortion family planning services,

(7) Social marketing,[1]

? Sustainable and cost-effective services, and

- Evaluation and research."

The agreement value of this Cooperative Agreement, from August 1993 through August 1998, is $118 million.

After the Cooperative Agreement was signed, four events occurred that affected its implementation: (1) the the passage of the 1993 Government Performance and Results Act, (2) the 1994 ICPD Conference, (3) the implementation of the USAID field support funding mechanism, and (4) a renewed strategic analysis and restructuring at AVSC. The first of these events, the passage of the 1993 Government Performance and Results Act, required all government agencies to develop strategic plans, including mission statements, goals, and objectives. Consequently, USAID developed a new strategic plan. Shaped by the outcomes of the Cairo conference, the strategic plan and results framework for USAID's Center for Population, Health and Nutrition (G/PHN) has four Strategic Objectives (SO):

- Increased use of voluntary practices by men and women that contribute to fertility reduction;

- Increased use of safe pregnancy, women's nutrition, family planning, and other key reproductive health interventions;

- Increased use of key child health and nutrition interventions; and

- Increased use of proven interventions to reduce HIV/STD transmission.

The second event, the 1994 ICPD Conference, brought together governmental and non-governmental officials to forge a new paradigm and consensus for a broader reproductive health framework. AVSC contributed to the development of this new consensus and has since been working to integrate the principles and recommendations from the ICPD Programme of Action into all of its activities.

The third significant change was the shift in the USAID funding mechanism from central, core funds to field support funds. This shift required that AVSC become more flexible and proactive in meeting USAID missions' needs. At the same time, mindful of the need to diversify its funding base, AVSC set out to secure additional donors for its expanding program.

The fourth significant event affecting AVSC's implementation of the Cooperative Agreement was significant internal AVSC change. In late 1995, AVSC's Board of Directors selected former Medical Director Amy Pollack, to succeed Hugo Hoogenboom as president. During 1996, AVSC

undertook a new strategic analysis of its mission, strategies, and structure. It revised its mission, established in 1992 in the *Strategic Plan to the Year 2000 for the Association for Voluntary Surgical Contraception*, which stated in part:

> The Association for Voluntary Surgical Contraception works to make safe and voluntary surgical contraception a known and real choice for all women and men everywhere. Surgical contraception includes female sterilization, vasectomy, implants, intrauterine devices, and other methods that require medical procedures.

The mission statement also mentioned improving quality; promoting free and informed decision making; improving the lives of women, men, and families around the world; and contributing to national social, economic, and environmental goals. Furthermore, it specified the following AVSC activities: information and technical assistance, service provision, training and policy development, and the introduction of new approaches to surgical contraception.

The new AVSC mission, drafted in 1996, stated the following course of action:

> AVSC International works worldwide to improve the lives of individuals by making reproductive health services safe, available, and sustainable. We provide technical assistance, training, and information, with a focus on practical solutions that improve services where resources are scarce. We believe that individuals have the right to make informed decisions about their reproductive health and to receive care that meets their needs. We work in partnership with governments, institutions, and health care professionals to make this right a reality.

Additionally, AVSC redesigned its structure and updated its management and financial systems. Multidisciplinary teams contributing to strategic goals replaced functional departments, and AVSC delegated greater authority to field offices. A new financial system, developed in 1995, provided data on the newly restructured organization with each goal and program being a cost center.

1.2 This Evaluation

This evaluation's Scope of Work (SOW) (See Appendix A) was carried out by a four-person team in the fall of 1997. The team met in Washington for a briefing with USAID; traveled to New York for four days of meetings with AVSC; and spent five days in Kenya, six days in India, and six days in Nepal working with AVSC staff and counterparts. During those 18 days, the team viewed clinical service delivery procedures, such as minilaparotomy, vasectomy, and NORPLANT?, in sixteen service delivery sites in Kenya, India, and Nepal; observed two training events in India; and interviewed twelve different host-country counterpart institutions in Kenya,

India, and Nepal.

The team also interviewed staff from the following key Cooperating Agencies (CA):

- International Planned Parenthood (IPPF)/Western Hemisphere Region and IPPF/London;
- Family Health International (FHI);
- Program for International Training in Health/Primary Providers' Training and Education in Reproductive Health Project (INTRAH/PRIME) at headquarters and in India;
- Johns Hopkins University/Population Communications Services (JHU/PCS) in Kenya and Nepal;
- Population Council in Kenya, India, and Nepal;
- Johns Hopkins Program for International Education in Reproductive Health (JHPIEGO) in Baltimore, Kenya, and Nepal; and
- Family Planning Services Expansion and Technical Support Project (SEATS) and Pathfinder in Kenya.

The team read materials supplied by USAID, AVSC, and counterparts. Particularly useful was the excellent "Background Paper for USAID Evaluation of AVSC International 1997," prepared by AVSC for the Population Technical Assistance Project (POPTECH). This background paper addressed USAID's SOW questions to AVSC.

The Office of Population (G/PHN/POP) sent an e-mail (see Appendix D) to relevant missions soliciting their input on AVSC's performance and on priorities and mandate for the future Cooperative Agreement. The response from the missions was excellent and yielded important feedback for this evaluation. The team held phone and in-person interviews with other missions. Altogether, there were e-mail responses, phone calls, or interviews with 21 USAID missions or offices in Egypt, Indonesia, Turkey, Philippines, Bangladesh, Ukraine, Russia, Peru, Mexico, Paraguay, Honduras, Ecuador, Ethiopia, Nigeria, Tanzania, Zimbabwe, Uganda, Kenya, India, and Nepal, and in Kenya with the regional REDSO/ESA office.

2. ACCOMPLISHMENTS OF THIS COOPERATIVE AGREEMENT

This chapter outlines accomplishments of the Cooperative Agreement in terms of the logical framework outputs. Later chapters discuss accomplishments and contributions in detail.

2.1 Outputs and Indicators

The basis for this Cooperative Agreement was an AVSC proposal with an attached logical framework identifying 17 outputs, including sterilization targets, that were subsequently dropped. The remainder of the outputs in that proposal were similar to the following indicators, which are being used for this Cooperative Agreement. The Cooperative Agreement itself did not include a logical framework.

Indicators:

- National programs for the improvement of client counseling
- Internal review of voluntarism in AVSC programs
- National training programs for clinic-based methods
- Training impact studies
- Support for national male involvement programs
- Client-centered service management programs
- Quality assurance guidelines and references
- Client-focused research
- New and underserved populations
- Production of professional publications
- Journal publications
- Presentations at professional meetings

- Cost studies
- Technical assistance visits

AVSC has achieved progress in all of the revised Cooperative Agreement indicators, as defined by AVSC and USAID. For instance, AVSC describes the first indicator, "National programs for the improvement of client counseling," as portraying

> the extent to which AVSC has expanded and improved the availability of family planning counseling services by working with national programs (e.g., Ministry of Health [MOH] or other government systems that work nationwide). To be included, each country has to have a national program in place to support counseling.

Between 1993 and 1997, AVSC worked with 28 national programs, including that of the United States, to improve client counseling.

Other AVSC indicators present similar process-level data. Between 1993 and 1997, AVSC worked with 18 countries on male involvement programs, provided technical assistance in 37 countries for installing or improving national training programs for clinic-based methods, worked on client-centered service management programs in 29 countries, and worked to expand reach to postpartum and postabortion women in 35 countries. AVSC produced or revised numerous quality assurance guidelines or references, produced professional and journal publications, undertook client-focused research, delivered papers and provided technical assistance in over 40 countries. AVSC staff published over 37 papers in a variety of journals and books ranging from the *International Journal of Gynecology and Obstetrics* to *Nurse Practitioner*. (See Appendix E for AVSC's report on these indicators.)

2.2 Contribution to Strategic Objectives

After the 1993 Government Performance and Results Act was enacted, USAID developed Strategic Objectives (SO). In response to a request from G/PHN, with which AVSC has this Cooperative Agreement, AVSC classified its indicators under the Center's Strategic Objectives.[2] The majority of these indicators are classified under *SO 1*: "*Increased use of voluntary practices by women and men that contribute to fertility reduction*" and its four program results. See Appendix 6 for a matrix that classifies AVSC's work in individual country and global programs under G/PHN's Strategic Objectives. This classification shows that AVSC's program efforts are clearly pointed in the right direction; however, AVSC's process-level indicators prevent USAID or an external evaluation from assessing AVSC's contribution to program results.

USAID missions have also developed Strategic Objectives. The Office of Population's e-mail to the missions asked missions if they considered the AVSC program an important contributor to achieving their Strategic Objectives and in what specific ways AVSC was called to contribute. The response was affirmative; most missions spoke of AVSC's important role in expanding access to and quality of clinical and surgical contraception. One mission wrote

> AVSC was given formidable benchmarks in support of the mission's Strategic Objective of reduced fertility and improved maternal health in the public and private sectors. Not only did AVSC willingly accept the benchmarks, it also took the ball and...ran with it, with all the program improvements it has instituted so far.

Conclusions

AVSC has achieved the revised outputs, referred to now as indicators. It has invested great effort and commitment in country and global programs. Unfortunately, most of the results are visible only when process-level indicators are being employed. As will be noted in Chapter 5, as AVSC acknowledges and as many USAID missions noted, AVSC's evaluation has been relatively weak. The confusion in terminology between outputs and indicators has not strengthened this effort.[1]

As part of the SOW, the team collaborated with AVSC/New York and AVSC staff in Kenya, India, and Nepal to develop ten results and accompanying indicators for the new Cooperative Agreement (see Chapter 7). These results and indicators are designed to have a higher level of impact than the outputs and indicators of the present Cooperative Agreement.

[1] An output is the result of program effort while an indicator is a characteristic or dimension used to measure the intended change. Indicators should be representative (show the status of the program), measurable (indicate if progress is being made), economical (balance cost by value), and temporal (have a time dimension).

3. COOPERATIVE AGREEMENT MANAGEMENT AND ORGANIZATION

3.1 AVSC Mission and Cooperative Agreement Mandate

In 1996, AVSC revised its mission from one of surgical contraception to one of reproductive health. However, AVSC's work in the field through this Cooperative Agreement continues to be focused on surgical contraception, or as it is commonly referred to by USAID missions, long-term and permanent methods. Most USAID missions that responded to the evaluation's questions wrote or spoke about long-term and permanent methods such as female sterilization, vasectomy, NORPLANT, and postpartum IUDs. It is these activities to increase access to and quality of clinical contraception that most missions identified as critical contributions to their Strategic Objectives. Moreover, as discussed in Chapter 7, the majority recommended that the follow-on Cooperative Agreement continue to be focused in this way. Accordingly, this report makes a distinction between the AVSC mission and the Cooperative Agreement mandate that is a subset or strategy of AVSC's mission.

3.2 Structure and Staffing

3.2.1 Structure

AVSC staff describe the organization as constantly remaking itself. This process has been intense over the past few years, driven by a number of factors: the ICPD, a new AVSC president, changes in USAID's funding mechanism, and response to the last AVSC evaluation and to AVSC staff's input at 1994 and 1995 strategic planning exercises. In early 1996, AVSC reorganized itself according to the following six newly defined corporate goals. Table 1 shows these goals and the programs serving those goals of greatest interest.

Table 1

AVSC Corporate Goals and Supporting Programs

AVSC Corporate Goal	Program Contributing to Goal
Country Programs	33 country programs
Program Innovations	Quality improvement
	Client perspectives
	Postabortion care
	Advances in informed consent
	Men as partners
	Reproductive health linkages
	Program innovations
Development and Public Affairs	
Reproductive Health Technical Resources	Clinical services support
	Training
	Contracts
	Technical publications
Knowledge Management	Research
	Technology
	Evaluation
	Knowledge Management
Resource Management	

A "goal manager," who sits on an eight-member executive team, defines the objectives for the particular goal and identifies the programs that support the goal. Because of the number of country programs, managers supervise senior managers, who in turn "supervise, direct, and

support" groups of program managers, who "plan, direct, and manage" programs in individual countries. Senior managers are located in New York and the field and have responsibility for two to five country programs each.

3.2.2 Field Offices

AVSC establishes field offices in locations where it is working with a major donor and service delivery system. It currently has 22 field offices of various sizes and types, a few of which serve multiple country programs. The larger offices such as Bangladesh, Kenya, and India are staffed with a dozen or more employees, while the smaller offices are comprised of only several people. Within the April 1997 decentralized program structure, program managers in these field offices have the authority to "carry out approved plans within approved budgets." In its "Background Paper for USAID Evaluation of AVSC International 1997," AVSC indicates that the program managers will have the following responsibilities:

> develop long-range strategy, project fiscal year plan and budget, decide what activities will be conducted within the year, identify resources required, secure approval of annual plan and budget, implement, lead the program team and direct its work, maintain spending within budgeted levels, evaluate effectiveness of program activity, and keep activities on track with program plan.

Program managers may not redirect the approved plan without their supervisors' approval, nor enter into subagreements that are not identified in the approved plan. Also, they may not directly hire any professional staff; AVSC/New York hires all professional staff and senior management assigns individuals to particular teams. The team interviewed AVSC field staff who indicated that, on paper, they had sufficient authority.

There are advantages and disadvantages to field offices. When a program reaches a certain level of effort, it becomes difficult to manage and provide technical assistance from afar. Therefore, a primary advantage of field offices is that they enable easier communication, greater attention, and higher responsiveness to local situations and institutions, including the USAID mission. AVSC's principal difficulty with field offices has been staffing them with highly qualified technical and managerial staff. One-third of the missions that provided input into this evaluation indicated that the country offices are, or had been until recently, weak in either managerial or technical (clinical) skills. Moreover, 5 of the 13 missions investing over $500,000 annually in AVSC's programs identified weaknesses in AVSC's field office staffing.

3.2.3 Staffing

AVSC's staff currently number nearly 200 worldwide; over half of this staff live and work in more than 20 countries in Asia, Africa, Latin America, and the former Soviet Union.[3] The field staff the team met are bright, dedicated, and entrepreneurial. They are led by a committed and talented New York-based, eight-person executive team. However, as noted in the last external evaluation, this team has little experience living and working in the field; one member of the team worked in the field 20 years ago. Recently, an important headquarters program manager position, for which the team believes field experience would be an absolute prerequisite, was filled by a person with no field experience.[2]

AVSC has a new senior director of human resources and states that a review of their human resource system is a priority.

3.3 Financial Management and Reporting

3.3.1 Budgets and Expenditures

USAID obligated $72 million to the Cooperative Agreement through December 31, 1996; AVSC expended $58 million through March 31, 1997. Core funds are about 20 to 25 percent of the total; in 1997, core funds represented $4.5 million in a $28 million budget.

AVSC introduced an excellent, new computerized financial planning and management system in 1995. It tracks financial activity by goal, program, country, and funding source. Field offices budget and report through computer spreadsheets that are transmitted to headquarters. In fiscal year 1998, AVSC will begin automating the conversion and posting of these reports to the ledger, eliminating data entry of a growing number of monthly field office reports.

Country programs report to New York and, in accordance with the terms of the Cooperative Agreement, AVSC/New York reports to Washington on all expenditures including field support funds.

Table 2 shows that in 1997, country programs (goal 1) were 76 percent of AVSC's total budget.[4]

[2] This issue was raised first by AVSC field staff.

Table 2

AVSC Budget by Corporate Goal for Fiscal Year 1997 to 1998

Goal	Budget ($)	Total (%)
Country Programs	21,559,785	76.0
Program Innovation	2,217,311	7.8
Development and Public Affairs	714,557	2.5
Reproductive Health Technical Resources	1,814,770	6.5
Knowledge Management	1,464,571	5.2
Resource Management	560,720	2.0
Total	**28,358,714**	**100.0**

During this Cooperative Agreement, AVSC has worked on or charged expenses to programs in over 62 countries. These include many important countries where AVSC has "comprehensive country programs" and others where AVSC has "limited programs," including a number of countries with tiny activities charged against them.[3]

- **Comprehensive Country Program**: One in which AVSC "builds comprehensive partnerships with the major service delivery institution(s) (major is defined as national in scope or having influence on the national scene) that result in a significant increase in access to quality reproductive health services." AVSC indicates that it will specify the increases on a country-by-country basis in each country's goal statement.

- **Limited Program**: One in which AVSC "develops or maintains a limited partnership with the service delivery systems to satisfy discrete or short-term country program needs and to leverage future program opportunities."

[3] These include 21 countries against which AVSC charged less than $50,000 since country-level cost centers were established. In a number of countries (Costa Rica, Gambia, Georgia, Nicaragua, Pakistan, Papua New Guinea, and Zambia) total expenses were less than $5,000.

In fiscal year 1997, AVSC worked in 27 countries. Table 3 groups these countries by level of funding. AVSC indicates that those country programs funded at approximately $500,000 annually are usually "comprehensive country programs." Although core funds support the headquarters management of "field operations" with a 1997 budget of $515,200, the remainder of the $21.5 million budgeted to country programs comes from field support and buy-in funds.

Table 3

AVSC Cooperative Agreement-Funded Countries by Funding Level

Country	FY 97 Budgets ($)
Cambodia, Egypt, India, Mexico, Nepal, Philippines, Tanzania	> 1,000,000
Bolivia, Kenya, Russia, Turkey, Ukraine	500,000 - 999,999
Central Asian Republics, Dominican Republic, Ethiopia, Ghana, Guatemala, Peru, Senegal	200,000 - 499,999
Guinea/Mali, Honduras, Indonesia, Jordan, Moldova, Paraguay, Morocco, Uganda, Zimbabwe	< 200,000

3.3.2 Financial Reporting

The evaluation SOW and e-mail query to missions asked if "USAID received the financial information it required to manage the Cooperative Agreement." G/PHN responded that it did receive sufficient information. However, ten missions responded that they did not receive sufficient information. Although they acknowledged that their relationship with AVSC was through a Cooperative Agreement and that they were therefore not entitled to direct, detailed reporting, many missions expressed frustration with the consequences. Some missions commented that the reports coming from Washington were always late. They wanted more frequent reports. Other missions indicated that they wanted more detail. As one mission that invests over $500,000 annually in AVSC's program stated:

> ...we are held accountable for results these days. How can I manage wisely when I don't know how a CA is spending our money? Field support funds are our money. We need to know how they will be and are being spent, but we are in a terrible bind. We are not allowed to ask fundamental managerial questions so we do without data we should have. If the system isn't changed, it seems all we can do is put the work out for contract.

Conclusions

AVSC's decentralized program structure looks good and it appears that sufficient authority has been delegated to field offices. However, it is too early to judge how the new organizational structure will work for field offices and missions.

The field offices, placed where there are funds and a work load sufficient to make a local office an efficient management structure, enable AVSC to better serve its major client: USAID missions. AVSC, should address two field-related problems. The first problem is its field recruitment and hiring procedures. AVSC should begin with an analysis of the management and technical skills necessary to carry out a successful AVSC program in accordance with mission priorities and requirements. Although hiring high-quality managerial and clinical staff may be difficult in some countries, it should not be difficult in the countries with large comprehensive programs where AVSC needs such skills and where missions identify staff weaknesses.

The second problem, insufficient financial information available to missions on field support funds, is really USAID/Washington's responsibility, but AVSC field staff and missions bear the consequences of this problem. From a management perspective, it is understandable that USAID missions would like to know how a CA would propose to spend $500,000 annually to achieve results for which the mission is held accountable. It is also understandable that missions would like regular reporting to help them gauge whether programs are on track. Some AVSC and mission staff have suggested "informal reporting" as a temporary solution; however, this is an uncomfortable, stopgap solution to the problem.

The difference in perspective that one gains from living and working in the field versus living and working in headquarters results in a difference in paradigms. To form common paradigms and minimize differences, many international agencies including USAID make field rotation a requirement for some staff and make field service a requirement for all new program staff. AVSC would benefit from the rotation of representative senior managers and program managers into New York at senior or executive team positions. Such a field perspective, brought into headquarters at a senior level, would provide a "reality test" as AVSC/New York considers new technical and programmatic directions.

Recommendation

1. AVSC should review its recruitment and hiring policies to ensure the following:

- All new New York-based staff in mid- and senior-level program positions have field experience in developing countries,

- Comprehensive country programs are adequately staffed with professionals with technical and managerial skills, and

- Missions should receive quarterly expenditure and pipeline reports. (Recommendations #13 and #16 in Major Conclusions and Recommendations)

4. AVSC-ASSISTED SERVICE DELIVERY

This chapter describes AVSC-supported services: those funded by the Cooperative Agreement and other services, funded by other resources and/or undertaken in response to AVSC's broader mission.

4.1 Female Sterilization

Voluntary surgical contraception (VSC) has been at the core of AVSC's work since its inception, and the expansion of VSC is at the purpose level of this Cooperative Agreement. The team observed female sterilization procedures in AVSC-facilitated service delivery points in India and Nepal. In India, AVSC is a major player in promoting access to sterilization services in Uttar Pradesh where laparoscopy and minilaparotomy techniques are used. Laparoscopic services are often used in camp situations; they will continue and be upgraded by infection prevention and laparoscope technical refresher training. A member of the evaluation team observed two laparoscopies under local anesthesia done by skilled surgeons. Each surgery lasted less than eight minutes with essentially no discomfort to the patient.

In Uttar Pradesh, the switch to all minilaparotomy services will be gradual; recent minilap trainees who are already skilled laparoscopists are still on the minilaparotomy learning curve. The team observed two surgeons perform one minilaparotomy each. These two minilaparotomies took 20 and 30 minutes respectively and during each procedure the patient was visibly uncomfortable[5]. The surgeons performing the procedures did not know how to effectively use the uterine elevator, partly because they were using an old operating table. Moreover, these newly trained obstetrician/gynecologists (OB/GYN) will be required to rotate with other medical officers, who are untrained in minilaparotomy, to other parts of the OB/GYN hospital every three months instead of remaining at the postpartum center where family planning and minilaparotomies are provided. Such potential gaps in service delivery will adversely affect clients' ability to obtain timely services, thus impairing access until all eight to nine OB/GYNs are trained or until changes are made in the current rotation system.

One minilaparotomy was observed at a Family Planning Association of Nepal clinic. The operator did not use the uterine elevator well and did not follow the standard Pomeroy technique. This surgeon's minilaparotomy and no-scalpel vasectomy (NSV) skills will need to be updated before the surgeon becomes a field trainer. As a field trainer, he will be responsible for supervising newly trained doctors immediately after their courses to help them go from basic competence to confidence while performing a large number of cases in a short time.

4.2 Male Sterilization and Men As Partners

Male sterilization has not been widely used in most developing countries, nor, according to the latest available data, has its global use been increasing even though (1) it is an easier procedure than female sterilization; (2) a technically superior method of vasectomy is available; and (3) there have been efforts at improving promotion and supply.

In 1988, worldwide use of vasectomy was 5 percent, while use of female sterilization was 13 percent.[6] The last data from 1994 show that the global percentage of current users, based on couples with the woman of reproductive age, was still 5 percent for vasectomy and 17 percent for female sterilization.[4] In less developed countries, excluding China, usage was only 3 percent for vasectomy and 14 percent for female sterilization. However, in sub-Saharan Africa users of vasectomy are only .1 percent, compared to 1 percent for users of female sterilization.[5]

AVSC reports that over a four-year period, 70,000 vasectomies were performed in AVSC-facilitated programs in 29 countries, an average of 600 procedures per country per year. Mexico accounted for the majority of the cases, with 1.5 percent use in 1987. Notably, AVSC has worked in Mexico with hospitals in the Social Security System, the largest and most reputable supplier of health care in the public sector. In addition, AVSC cooperated with two other well-established institutions, the MOH and the Social Security Institute for State Employees. Both of these well-accepted institutions, where many people turn for general medical care, are supported by employee taxes, giving clients a stake in the quality of management and care.

Despite several years of interest in NSV in Kenya, vasectomies in AVSC-facilitated units have never exceeded 150 per year, and although 55.7 percent of male respondents to the 1993 Demographic and Health Survey (DHS) knew of vasectomy, reported use of male sterilization was 0 percent. Those familiar with the Kenyan program cite as limiting factors the lack of long-term information, education, and communication (IEC) effort and the absence of facilities that attract men? those with separate men's facilities and quality counseling by men.

Infrastructure, equipment, and supplies can also be limiting factors. One example of this limitation was the situation with a potential vasectomist whom the evaluation team interviewed in Uttar Pradesh. This young Indian surgeon, stationed at the lowest level of AVSC-directed services, had received vasectomy training nine months earlier. However, he had not yet received NSV instruments and was forced to cancel a small number of appointments with potential clients who could have formed the nucleus of a satisfied user group that would recruit other candidates. Moreover, his operation theater needed renovating before it could meet AVSC's minimal appearance and hygiene standards.[6] Because of these limiting factors, this surgeon will surely

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[4] "Levels and Trends of Contraceptive Use as Assessed in 1994," Department for Social Information and Policy Analysis, Population Division, United Nations, New York, 1996.

[5] IBID.

[6] The Uttar Pradesh project managers have experienced a slow response to renovation in general because these renovations require the work of the State of Uttar Pradesh's Public Works Department, which is usually occupied with large tasks such as road maintenance. Moreover, the purchase of any new equipment such as a new operating table must be bid on by three competitors to satisfy Government of India regulations.

require refresher training before he can provide services.

AVSC began a Men as Partners (MAP) program in 1996 and is encouraging a male reproductive health approach as being more productive than an approach emphasizing NSV alone. The concept is that men are equal participants in family affairs and are key to making joint decisions on issues such as contraceptive choice. Through this approach, AVSC hopes to enhance continuation rates. MAP goals are as follows:

- Increase men's awareness and prevention of STDs,
- Increase access to male methods of contraception, and
- Increase men's support of their partners' reproductive choices.

AVSC's MAP program, on which it has collaborated with nine different CAs, has produced a workshop, pamphlets, posters, videos, and updated training materials. AVSC is committed and passionate about MAP and identifies several features unique to the MAP program: long involvement with service to males, client-centered methodologies, training and educational materials, and a willingness to undertake operations research using their own resources to improve access. Yet, at the grassroots level in Kenya and India, little excitement and energy is devoted to MAP compared to the magnitude of effort devoted to more conventional programs supporting female sterilization, IUDs, NORPLANT, and quality management tools. Other country programs not visited during this evaluation? South Africa, Ghana, Tanzania, and Pakistan? have reportedly shown greater interest in MAP.

In contrast to Kenya and India, Nepal has a longstanding, increasingly successful MAP program. In this program, 16,537 and 19,157 procedures have been performed in the last two years and use of vasectomy was 5.4 percent in 1996. This success is due to the skill and enthusiasm of Dr. Tika man Vaidya, a highly regarded, long-time practitioner of NSV whose reputation continues to facilitate acceptance of vasectomy although he no longer practices regularly.

In May 1997, AVSC convened a workshop in Kenya to create MAP country workplans. This workshop was attended by representatives from Egypt, India, Pakistan, and six sub-Saharan nations. Although country participants presented different strategies and activities, they identified three issues requiring increased action: broad dissemination of IEC, friendly and sensitive counseling by other men, and quality service delivery sites. Currently, AVSC is collaborating with IPPF/Latin America to plan a regional conference for a variety of Latin American participants to look at issues such as masculinity, fatherhood, and domestic violence, as well as two concepts concerning male involvement in family planning: gender equity and STD prevention.

Several AVSC papers have examined factors that lead to a successful men's program. The 1997 paper, "Profamilia's Clinics for Men: A Case Study Based on 10 Years' Experience in Colombia," noted the following:

- Strong leadership within the organization is needed to initiate services for men.
- Lessons learned from working with men can be applied to women's services.
- International exchanges help organizations to improve their services.

An AVSC paper, *Lessons Learned: Male Involvement Work in Kenya* (Kirsh, 1997), on lessons learned in programs with non-governmental organizations (NGO) in Kenya presented the following conclusions:

- Anonymity within a clinic is more important than the locality of the clinic, e.g., whether a male clinic is freestanding or located within a conventional FP clinic. By offering a variety of health services, the clinic avoids the assumption that HIV/STD or vasectomy is the sole reason for attending.
- A motivated, sensitive staff in a comfortable, welcoming environment is critical to success.
- A sustained, carefully orchestrated reproductive health media campaign is essential.
- Outreach workers are powerful motivators.

Furthermore, in AVSC's paper Kirsh recommends the following:

- Include vasectomy in the promotion of male involvement in family planning activities.

- Conduct a sustained, radio-based media campaign over a year's time.[7]

- Make greater use of satisfied vasectomy clients to reach other men.

4.3 Increasing Long-Term Choices: NORPLANT and IUDs

NORPLANT, six Silastic rods that are inserted through a small incision on the inside of the upper arm, requires a minor surgical procedure with aseptic (infection prevention) precautions similar to those used in sterilization procedures. The duration of contraceptive action of the slowly absorbed steroid, levo-norgestrel, is five years; at the end of that time, the rods are removed and replaced if indicated. As a long-term method, NORPLANT has the advantage of a rapid return to fertility after removal—1 to 3 months—compared to Depo-Provera, which after five years of use requires at least nine months for a return to fertility. Although NORPLANT's initial cost is high, a cost-benefit analysis in Kenya revealed that after three and one-half years of use, NORPLANT's cost equaled the cost of Depo-Provera, when the follow-up visits and injection costs were included. NORPLANT has proved popular in Kenya; it was used by over 11,000 people in 1995 after its introduction in 1991.[7] A supply shortage resulted in decreased use in 1996; however, during 1997 this problem was rectified.

In Kenya, the evaluation team observed excellent services, including NORPLANT removal and reinsertion, performed by nurse midwives at a Family Planning Association of Kenya (FPAK) unit near Nairobi. If economically feasible, NORPLANT will be increasingly popular in Kenya. Second and third generation long-acting implants using levo-norgestrel will become available in the next few years: fewer, perhaps absorbable, rods and durations of action shorter than five years will make this type of contraception even more acceptable and less expensive.

Although AVSC's global service statistics are incomplete and data is available for only some of the AVSC-facilitated service delivery sites, the available service statistics on NORPLANT use relative to use of other methods are interesting. A summary of services provided in AVSC-supported programs (AVSC, n.d.) from 1992 to 1996 indicates that the annual number of reported NORPLANT clients more than tripled, while the reported number of both female and male sterilizations in 1996 dropped below that of 1992.

[7] AVSC/Kenya, JHU/PCS, and Innovative Communication Systems are currently discussing a similar collaborative program.

The postpartum placement of IUDs (postpartum intrauterine device [PPIUD]) was in disrepute for several years after a World Health Organization (WHO) study found that postpartum IUDs had too high an expulsion rate to justify general use. Within the past seven years, however, AVSC has led the way to revive the use of the IUD immediately following obstetrical delivery. In this procedure, the IUD may be used in two ways: immediately postplacental insertion (IPPI)? within 10 minutes? or insertion before hospital discharge (IBHD)? 48 hours after delivery. In either case, the high fundal placement of the IUD within the uterus minimizes spontaneous expulsion and the side effect of bleeding. In a paper from Nyeri Provincial Hospital in Kenya (Mate et. al., 1994), expulsion was reported to be 1 percent for IPPI and 5 percent for IBHD. These positive results were corroborated by data from Mexico and the Dominican Republic in 1995 and 1996.

The recent visit by the evaluation team to Nyeri Hospital revealed that although postpartum insertions were still done, only 4 percent of women who delivered were given a postplacental IUD even though all 12 midwives on the maternity service were familiar with the procedure. An active PPIUD program requires coordination between the antenatal, family planning, and labor and delivery services, as well as the interest of the director of maternity services. Although Nyeri Hospital Antenatal Clinic counsels women regarding PPIUD, use of this procedure has not increased since the clinic's initial evaluation three years ago.

4.4 Post-Incomplete Abortion Care

Post-incomplete Abortion Care (PIAC) is a three-concept package of services aimed at improving health care for women experiencing abortion complications. The three components are as follows:

- Providing emergency treatment services for complications of spontaneous or unsafely induced abortion,
- Providing postabortion family planning counseling and services, and
- Linking emergency abortion treatment services and comprehensive reproductive health care.

Since 1993, AVSC has taken an active role in organizing activities to protect women from severe complications of incomplete abortion? delayed treatment in hospital, infection, excess blood loss? and to coordinate opportunities for timely and efficient family planning after abortion.[8] AVSC is a founding member of a U.S.-based consortium to coordinate worldwide training,

operations research, and service delivery of PIAC. As mentioned, the evaluation team visited Kenya, one of eight countries in which AVSC has initiated PIAC activities.

During their visit to Nyeri Hospital,[8] the team interviewed two clinical officers (female paramedics) who had been trained by International Projects Assistance Services (IPAS) to use manual vacuum aspiration (MVA) to complete abortions where bleeding and infection were present. These two paramedics provide services with two female medical officers assigned as rotating interns. The team observed the paramedics perform several procedures and afterward gave some "facilitative supervision." It was not clear whether the PIAC process had been totally institutionalized in this unit because in their clinical year following training, the interns and paramedics rotate to other services and hospitals at monthly intervals. Thus, consistency and quality of services could not be verified.

The hospital recently completed a study testing three modes of providing postabortion family planning services. The study showed that the most efficient, effective mode of provision directly involved personnel on the GYN ward, where patients were monitored after MVA until discharge within 24 hours. Ward nurses counseled the women on site instead of sending them to the family planning outpatient unit or arranging for family planning personnel to leave their busy clinic to walk to the hospital site.

PIAC services in Kenya have been pilot projects of the MOH. They have occasionally suffered from insufficient supplies and inadequate continuity when trained providers were not available. Moreover, some Kenyan providers, such as the staff of the Christian Health Association of Kenya (CHAK) hospital, continue to favor the classic dilation and curettage (D&C) under general anesthesia after hospitalization for observation. JHPIEGO, however, is providing pre-service training for medical students, interns, and nursing students in PIAC. If the MOH encourages continued training and clinical practice, support and services will expand in the near future.

4.5 Infection Prevention at the Clinic Level

[8] Nyeri Hospital is one of six Kenyan hospitals where the MOH, AVSC, IPAS, and the Population Council carried out a two and one-half year operations research study on PIAC.

Reproductive tract infections (RTI) can occur in women spontaneously with variations in their personal hygiene or habits. RTI can also be transmitted by improperly cleaned clinical instruments such as a contaminated speculum or an improperly cleaned needle.[9] AVSC has worked to minimize such RTI transmissions. In each clinical facility visited, the team witnessed the practical knowledge and application of infection prevention. The team saw or discussed the proper use of chlorine solution decontamination, autoclave sterilization, and appropriate care and storage of instruments and gloves. All the inpatient and outpatient units associated with AVSC are, presumably, safer places for treating women as a result of the intensive infection training carried out over the past 10 years. Likewise, presumably, the burden of disease has been significantly lowered for clients and staff.

In all its activities, AVSC emphasizes the importance of STD issues and condom use not only for contraception, but also for protection against the spread of disease. These activities include Contraceptive Technology Updates (CTU), counseling training courses, training of trainers (TOT), and "In-Reach" efforts.[9] As supply allows, condoms are available for distribution at AVSC-supported sites.

4.6 Reproductive Health Services Not Funded by the Cooperative Agreement

4.6.1 Cervical Cancer

In the developing world, cervical cancer is the most common cancer in women. The human papilloma virus (HPV), which can cause cervical cancer, is the most lethal STD after AIDS and its spread can be prevented by condoms. After the lesion reaches its early invasive stage, it becomes symptomatic for the first time. At this juncture, it is curable in only 80 percent of cases when treated with advanced X-ray technology and/or extended surgery, which is not generally available in the developing world. The Pap smear is designed to detect earlier, preinvasive cases that are curable with simpler, less expensive measures; however, Pap smear technology is time consuming and expensive and not generally available to women who are treated in the public sector.[10] Pap smears will not be a regularly available option for most of the world's women in the foreseeable future.

Data from the United States drawn from STD clinics that predominantly serve women in their younger reproductive years indicate a 0.9 percent prevalence rate of high-grade squamous intraepithelial lesions (SIL), a precancerous condition more commonly known as severe dysplasia. These data suggest that screening to prevent invasive cervical cancer should begin

[9] "In-Reach" efforts include an orientation for all workers (including sweepers, gate guards, and cleaners) in an FP unit on basic concepts (counseling, infection prevention, and HIV/STD issues, as well as contraceptive choice).

when women are in their 20s and 30s, particularly in developing countries where women often initiate regular sexual activity at an early age. Classically, cervical cancer becomes symptomatic in women in their 40s, although it may have been in a preinvasive stage for up to 10 years. With an earlier onset of sexual activity and increased likelihood of multiple partners, the timeline is often shorter so that abnormalities can be diagnosed in women in their 20s or 30s.

With private funds, AVSC is taking the lead in research to evaluate whether these early preinvasive areas on the cervix can be reliably diagnosed by the naked eye during a speculum examination, such as would occur in the preparatory phase of a minilaparotomy. An internationally known pathologist is supervising a carefully controlled clinical program. The program's preliminary results should be available within two years. Assuming that results are encouraging, a significant innovation would then be required to test minor surgical treatments of precancer of the cervix that can be applied within the constraints of developing countries.

4.6.2 Sterilization Reversal

AVSC has recently completed the final evaluation of the UNFPA-funded Centers of Excellency project in India. This project was designed to train specialists in reanastomosis techniques to respond to the needs of those who have undergone sterilization operations and desire reversal. The project was considered successful because it met the national need to respond to those who had been unaware of the finality of the operation or those who had lost children and wanted to have more. Trainers from these centers are ideal instructors for NSV and are well prepared to function in advanced family planning programs such as the USAID-funded program in Uttar Pradesh.

4.6.3 Emergency Obstetrical Care

Maternal death and serious morbidity or disability profoundly affect a whole family and thus child survival. Current interest in this serious medical problem focuses on what emergency obstetrical care (EOC) might be made available, especially in the increasingly urbanized areas of many developing countries. AVSC will be involved in EOC in the Bangladesh bilateral project, for which AVSC has the quality improvement contract, because EOC is a component of the "basic package of services" that the bilateral project is developing. In other countries where AVSC is developing a narrower range of services, it is likely to be involved to the extent that these services involve aseptic technique and surgical approaches to treatment.

Conclusions

While maintaining its primary focus on sterilization activities, AVSC has used its approaches to service delivery in an expanding circle of quality reproductive health services that use the basic principles established for sterilization. The sensitive issue of introducing a surgical procedure to produce permanent control of fertility demanded strict adherence to the doctrine of completely informed choice and provision of as many alternate family planning modalities as possible. Early in the evolution of highly visible projects for female and male sterilization in developing countries, AVSC confronted the possibilities of setting targets for the number of recipients and resultant coercion. It overcame these dangers in the clinics it directly supervised by ensuring strict supervision and enlightened, intensive counseling training. AVSC's experience with all aspects of service[11] enabled AVSC to apply its counseling and surgical principles to other family planning choices, such as NORPLANT, that require the precepts of modern surgery.

However, some women accepting minilaparotomy sterilization in developing countries seem to be experiencing greater pain than their U.S. counterparts who have access to drugs for conscious sedation not generally available in minilaparotomy programs. Although it is impossible to generalize to every country doing minilaparotomy with local anesthesia, a similar concern regarding pain relief was expressed during AVSC's 1991 midterm evaluation.[10] In addition, unsolicited corroborations of this perioperative issue have been expressed by three consultants to international FP programs who have observed minilaparotomy with local anesthesia procedures in various countries during the past five years.

Over the past 10 years, however, new drugs, synthetic opioids, and short-acting benzodiazepines have become available in less expensive generic brands. These drugs can be given safely intravenously and can provide excellent pain relief, including a degree of amnesia for the operation itself. These drugs are currently the standard of care in developed countries to support local anesthesia in procedures such as minilaparotomies that enter the abdominal cavity.

AVSC has not studied clients' experience with pain relief during and immediately after an operation and how pain relief affects client satisfaction. Although a 1995 AVSC-commissioned survey asked 500 men and 500 women in Nepal about their satisfaction with their VSC services, the study did not evaluate the degree of discomfort or pain experienced, nor did the study evaluate pain relief during and immediately after the operation. Furthermore, there has been no assessment of long-term feelings about pain to determine how such feelings affect client satisfaction and referral. Conscious sedation may increase the acceptance of tubectomy; such a result could be verified by operations research conducted in one or more countries with mature,

[10] The 1991 Midterm Evaluation of AVSC recommended that ?AVSC should give more attention to sedation, analgesia, and anesthesia in the context of VSC and should involve more anesthesiologists and/or anesthesia technicians in AVSC training and service delivery programs.?

stable minilaparotomy with local anesthesia programs.

High levels of support should be sustained so that AVSC can continue to intensively develop the MAP initiative, which includes specifically the expansion of NSV. Raising consciousness and providing training are essential, but as the team observed, so too are infrastructure, equipment, and supplies. Further, leadership is vital, as seen in countries as disparate as Brazil, Colombia, Turkey, and Pakistan that have had small but successful programs, based primarily on the powerful leadership of an enthusiastic vasectomist who vigorously and devotedly generates interest and provides excellent personal services. Vision and leadership are necessary to energize the solution to male issues surrounding vasectomy and egalitarian relationships with women.

The PAC initiative is a major contribution to women's health. Delayed treatment of abortion complications and neglected infection and excessive bleeding from those complications cause many maternal deaths.[11] Prompt treatment of these complications will decrease the use of valuable hospital facilities and the need for antibiotics. When PAC is fully implemented, septic abortion cases will rarely require hospital admissions, rather than filling many hospital beds.

Recommendations

2. As part of USAID and AVSC's continuing efforts to improve quality of care (QOC), AVSC should consult with an OB/GYN analgesia expert to consider better perioperative pain management for minilaparotomy with local anesthesia. (Recommendation #3 in Major Conclusions and Recommendations)

3. In two to three years, AVSC should consider initiating plans to collaborate with like-minded persons and organizations to hold an international meeting on Men as Partners. Contributions should be solicited from professionals in a broad range of specialties, such as psychology, anthropology, and ethics and religion, as well from those in the forefront of service delivery. (No corresponding Recommendation)

4. As AVSC moves to promote MAP at the field level, it should view vasectomy services, one component of MAP, in their totality. In every country where AVSC, in collaboration with USAID and host-country counterparts, decides it is important to improve access to and availability of vasectomy services, AVSC should review all the components of planning and managing such services to ensure that each component is functioning well. (See Table 4 "A Checklist for Planning and Organizing Clinical Services" in Chapter 11.)

[11] Such complications are variously estimated to affect 10 to 30 percent of the 500,000 women who die annually as a result of a pregnancy complication worldwide.

A written plan should identify CA's responsibilities to lead or facilitate various components; identify any gaps or weaknesses (whether leadership, IEC, provider competence, infrastructure, or supplies); and specify activities to address those gaps or weaknesses. (Recommendation #2)

5. AVSC should add PAC activities to its clinic-based activities whenever possible and appropriate. As AVSC and other CAs expand these services, they will have to give close attention to all components of the service in the same manner recommended for vasectomy. (Recommendation #4)

6. Consonant with the wide-ranging interests of AVSC, the search for a medical director should be international in scope. In support of the current president, who has significant medical expertise, an ideal candidate would have clinical training in OB/GYN, experience in public health and/or an MPH, familiarity with clinical/operations research, interest in modern medical training and teaching modalities, and field experience in a developing country. (No corresponding Recommendation)

5. CAPACITY BUILDING FOR QUALITY SERVICE DELIVERY

5.1 Capacity Building and Sustainability

AVSC has long worked to improve the quality of family planning services, especially sterilization procedures. Quality assurance approaches focus on activities such as the following:

- Training health care providers in the delivery of methods and in the value of counseling and informed choice;
- Developing standardized protocols, service delivery guidelines, and standards for specific methods;
- Training trainers and others to use these standards;
- Establishing systems such as medical records, complications reporting, and mortality reporting to assist in monitoring the implementation of these standards; and
- Identifying new and safer ways to provide these methods.

AVSC's approach to quality assurance has evolved most significantly during the current Cooperative Agreement with USAID. However, the approaches and tools AVSC uses are still "works in progress." As AVSC moved from a project to program focus during the last Cooperative Agreement, it became concerned with sustainability and its staff's ability to monitor quality in their work sites. In the process of examining how to provide quality family planning services, AVSC found that clients' perspectives were often lacking; family planning services were fragmented and vertical; training was often inappropriate, narrowly focused, or unsupported; and supervision often took an auditing rather than supportive approach. However, as a result of this analysis, AVSC invested in tools and approaches that are still being refined. These tools and approaches can meet service delivery-specific needs:

- Problem identification and problem solving at the service delivery site;
- Empowerment for and ownership of the quality improvement process leading to sustainable improvement of supervision, including reconnecting supervision and training;
- Technical competence and quality assurance; and

- Access to services and linkages between services.

At the same time, AVSC adopted a quality improvement approach to their work with a core principle to meet customer's needs. AVSC helps country programs and local institutions build their service delivery networks by focusing on three critical areas: (1) client rights and needs (see Chapter 7), (2) provider needs, and (3) country and institution needs.

G/PHN/POP's e-mail survey asked USAID missions if AVSC focuses sufficiently on sustainability. The majority of missions indicated that AVSC was working diligently and effectively on that issue. For instance, missions noted the following: AVSC subagreements contain provisions for cost sharing, (2) "business plans" had been developed for medical universities, (3) fee schedules had been established, and (4) AVSC had been strengthening institutional capacity. However, several missions wrote cautionary notes about sustainability, noting that in their countries the focus must be on making services accessible and available. One mission wrote

> Sustainability is a difficult issue and does not come easily. Achievement is one part of a much broader program that can only be possible within the context of the national health program and goes hand-in-hand with socioeconomic development....While we support AVSC's activities towards sustainability and institutionalization of reproductive health services, it is vital for AVSC to ensure that adequate quality services are available to those that need them. Textbook approaches to sustainability will not work and could even lead to situations where long-term and permanent methods could be seen to be only for or available to those who can afford them.

5.2 Quality Improvement Package

5.2.1 Client-Oriented, Provider-Efficient Services

Client-oriented, provider-efficient services (COPE) is a low-technology technique to improve services for clients in which local health care provider teams assess their own work to identify and find solutions to problems in their facilities. COPE is a five-step process: (1) problem identification, (2) discussion of causes, (3) solution identification, (4) assignment of responsibility for resolving problems, and (5) setting a deadline for resolution. The COPE instrument includes a section on raising provider consciousness about client quality needs and rights. This tool, first developed in 1989, has been refined since its introduction (Dwyer et. al., 1991). In 1995, AVSC published a handbook on COPE and has since translated COPE tools into Bangla, Spanish, French, Russian, and Urdu.

Between 1993 and 1997, AVSC staff introduced COPE in more than 25 countries. (See Table 1.1, in Appendix 6 for a list of countries where COPE has been introduced.) The introduction of COPE has been more widespread in East and Southern Africa than in any other region, although it is increasing in Asia. In 1993 to 1994, two organizations in Kenya?FPAK and CHAK?adopted COPE and incorporated the processes and tools as part of their regular, routine approach to supervision (although FPAK management is scheduled to implement COPE for the first time this year in their new AVSC subagreement).

The evaluation team observed the client flow analyses (CFA) posted in several FPAK clinics and in one CHAK hospital. Staff at the CHAK and FPAK clinics cited several improvements that had occurred as a result of COPE exercises. Furthermore, at one CHAK hospital a maternal COPE module had recently been piloted. Although only one staff member present in the maternity ward had attended the COPE session (some staff had transferred and most participating in COPE worked the night shift), the staff had produced an action plan identifying problems and their solutions. Of 12 problems identified, 3 had been addressed and 2 solved. The COPE session was conducted by a trained supervisor with an AVSC staff member observing. The hospital's chief medical officer complained to the evaluation team that the COPE session had been improperly handled because the facilitator did not possess proficient facilitation skills.

In June 1996, the Division of Nursing in the Kenyan Ministry began formal training for nursing officers in charge of provincial, district, and subdistrict hospitals in AVSC's quality improvement principles and COPE. The evaluation team found that COPE had not been conducted in several years in one district hospital where several of the staff had been trained as facilitative supervisors. As stated, COPE had started in the MOH facilities several years before. The evaluation team met with a committee of regional supervisors from one district and discussed COPE with the trained facilitator. Also, the team reviewed the reports from one facilitative workshop, Machakos, and noted that several provinces had planned to conduct follow-up COPE exercises.

In India, COPE will be introduced in the second phase of strengthening exercises once the service sites are upgraded and staff trained in counseling and infection prevention. AVSC notes that these basics need to be in place before COPE is introduced. In Nepal, AVSC conducted sessions several years before in one clinic, Chetrapati, where the QOC manager reported that many problems had been resolved soon after the action plan was developed. A CFA had not been conducted and no follow-up sessions had occurred because, AVSC reports, the mission had directed AVSC to discontinue in-country COPE activities. AVSC/Nepal now plans to begin COPE in selected facilities.

AVSC continues to adapt and modify COPE. Separate draft modules exist for infection

prevention, maternity services, postabortion care, and sterilization. AVSC is revising COPE to address broader reproductive health care. In July 1997, AVSC received additional funding from USAID's Africa Bureau to adapt COPE for child health services.

AVSC conducted two evaluations of COPE use in Africa? one in 1992 (Lynam, Rabinovitz, and Shobawale, 1993), the second in 1994 (Rabinovitz, Smith and Berhman, 1994). In addition, in Bangladesh and Tanzania, two recent program evaluations of AVSC's quality improvement approaches included a review of COPE. However, these evaluations are process-oriented, relying on providers' self-reported changes following COPE. These evaluations are supported by anecdotal incidents that compare number of problems identified and resolved, examine clients' perceived changes in services, and compare patient waiting times. Only in one case did these evaluations attempt to examine changes in service use.

5.2.2 Summary of Recent Evaluations and Midproject Reviews in Tanzania and Bangladesh

The 1992 evaluation study consisted of three main components: (1) a table listing problems and proposed solutions identified by clinic staff at the first COPE exercise (to review and note changes made), (2) the client flow analysis summary sheet and graph from a second CFA exercise (to compare with the first CFA), and (3) a structured interview questionnaire for service providers who had participated in both COPE exercises. According to the study "Using Self-Assessment to Improve the Quality of Family Planning Clinic Services" (Lynam et. al., 1993), facilities reported resolving 59 percent of problems identified, or 73 percent of the problems that could be solved, without seeking outside help. The problems that were most often solved by the COPE follow-up visit were as follows:

- Need for more staff training in family planning,
- Lack of a forum to discuss family planning issues,
- Lack of signs directing clients to the family planning unit,
- Long waiting times for clients,
- Unavailability or inadequacy of family planning supplies, and
- Incomplete records and delays in record retrieval.

Waiting periods declined by 17 to 56 percent, with an average drop of 42 percent. Providers reported positive results from COPE, including decreased client waiting times, increased

consciousness of clients' needs for attention and privacy, increased staff cooperation and communication, improved morale and commitment among staff, and fewer supply shortages.

The 1994 evaluation was a year-long prospective study to assess COPE's effects on clinic services, and its reported effects from client and provider perspectives. This evaluation also examined the number of problems identified and solved, compared CFAs to measure changes in client waiting time, interviewed providers about changes that may have occurred due to COPE exercises, interviewed clients about changes they had noticed, and attempted to review client records and service statistics. The study found that clinic staff had resolved 66 percent of the problems identified. Only two of four clinics had improved client waiting times, while one clinic's times had remained the same and one had worsened. Clients were satisfied with the services and noted positive changes, especially six months after the COPE exercise had been conducted. However, no conclusions could be drawn about changes in the information, education, or counseling services for clients following COPE introduction. The original study intent?to examine changes in service statistics over time, review the completeness of records, and review the sterilization client logs?was abandoned due to problems with record keeping, data collection, and changes in reporting systems.

The purpose of the Tanzania review was to assess the use of AVSC-developed quality approaches and tools and document lessons learned to determine needed modifications. COPE had been introduced in 13 of 16 Tanzanian sites. Representatives from most departments had participated in at least one exercise. COPE was recognized as contributing to the improvement of quality services. In most facilities, non-family planning staff were aware of COPE and understood its purpose. Of COPE's four components, the self-assessment guides and action plans were most familiar to management and family planning staff; CFA had not yet been introduced. Most facilities visited followed the five-step process consistently, and COPE action plans were prominently displayed. Staff addressed similar problems as in the other studies. The constraints identified by staff to conducting the COPE exercise include the cost and logistics of copying guides and client interview forms.

The evaluation of the Bangladesh Systems Approach project addressed the primary question of whether the project successfully strengthened the selected components of the family planning system. Evaluation data came from background documents; reports prepared by AVSC; and interviews with managers, supervisors, service delivery personnel, and clients. The study found that through the identification of problems and solutions, COPE provided a valuable and useful quality improvement tool for local planning. At the Thana (district) level, service providers who participated in the COPE exercises overwhelmingly reported that they had changed their attitudes and behavior. Providers also reported that they were now more aware of and responsive to client needs and rights and indicated that they paid increased attention to counseling, infection

prevention, and client screening.

5.2.3 Facilitative Supervision

AVSC's most recent quality tool is facilitative supervision, an approach that emphasizes mentoring, joint problem solving, and two-way communication between supervisors and their staffs and builds on the approaches to medical monitoring and supervision that AVSC has developed over the last 20 years. In facilitative supervision, the supervisor's key role is to meet providers' needs in support of their efforts to provide services to clients. AVSC introduced facilitative supervision in Bangladesh, Kenya, Madagascar, Tanzania, Uganda, and Zimbabwe. AVSC also introduced facilitative supervision for specific technical areas, such as counseling, in Nepal and the Philippines.

Per *AVSC Working Paper No. 10*, facilitative supervision is introduced in three stages: orientation, assessment of the quality-improvement process, and development of complex supervisory skills.

- Stage I includes a workshop with supervisors that focuses on the following activities:
  - Assessing institutional and service-site interest in quality improvement;
  - Introducing the concept of quality management and helping staff think about quality in relation to their jobs;
  - Discussing the roles and needs of facilitative supervisors;
  - Developing communication skills;
  - Understanding links between supervision and training, including an introduction to adult learning theory; and
  - Introducing COPE and In-Reach.
- Stage II workshop topics include the following activities:
  - Managing the quality improvement process;

- Setting objectives using the tools previously introduced;
- Organizing whole-site training, including skills training, orientation, and updates for all staff at the site;
- Performing on-the-job training and mentoring;
- Coordinating sites and headquarters; and
- Collaborating with other agencies.

? Stage III workshops build on the lessons learned in the two previous stages and introduce the following more complex supervisory skills:

- Training trainers;
- Using statistics and reports as a means of evaluating the quality of services;
- Using additional evaluation tools; and
- Engaging in networking.

5.2.4 Summary of the 1997 Midproject Reviews of the Facilitative Approach in Bangladesh and Tanzania

In 1997, AVSC completed midproject reviews of the facilitative approach in Tanzania and Bangladesh. The 1997 Tanzania evaluation documented lessons learned about the use of the quality improvement assessment checklist and AVSC's approach to facilitative supervision.

The purpose of the review was to assess (1) the supervisors' role, functions, and activities; (2) whether effective linkages had been established between all levels of supervisors; and (3) what more could be done to support supervisor's development. The review did not assess the program or the supervisory system but instead examined the new approaches and tools. During the review, three teams made site visits to 16 sites in six regions of Tanzania. Teams collected data from sites about the supervisory teams' activities, the use and usefulness of the quality approaches and tools, needed changes or improvements, and service statistics at the sites. Data was gathered

through observation and interviews with supervisory teams, ministry staff, family planning service providers, and clients visiting sites for family planning and other services. The evaluation also posed questions to supervisors about the extent of MOH staff involvement. Supervisors reported that supervision was now more "empowering," systematic, and supportive and that the approaches and tools used in the program allowed supervisors and site staff to establish an effective team and increase supervisor knowledge about the sites they supervise. When asked to rate the usefulness of the approaches and tools, most supervisors rated them one to two on a scale of one to four (with one being most useful). Supervisors and site staff concurred that supervisory visits were now more frequent. When asked to describe the last supervisory visit to a particular site, both groups reported the following reasons for the last visit:

- Distributing expendable supplies;
- Collecting statistics;
- Observing permanent and long-term services, with regard to technical and counseling skills;
- Conducting COPE follow-up;
- Conducting on-the-job training (OJT) follow-up;
- Providing updates on infection prevention or permanent and long-term methods;
- Introducing NORPLANT;
- Coaching or demonstrating skills; and
- Providing feedback to trainees.

The ultimate objective of the strategy in Tanzania is to build a supervisory capacity for sustainable, safe, and quality services whereby the MOH supervisors participate in and ultimately assume responsibility for many of the supervisory activities now undertaken by UMATI's (Tanzania's Family Planning Organization) outside mobile team supervisors in permanent and long-term methods.

The evaluation of the Bangladesh Systems Approach project found

> facilitative supervision workshops contributed to strengthening the supervision component of

the family planning system. Supervisors who participated in the workshops indicated they were now more concerned with helping their supervisees, and were less directive and more facilitative in their behavior toward them. The evaluation did not attempt to answer the question of the impact of strengthening the components on the quality of services or the contraceptive method mix.

In Kenya, the evaluation team met with a committee of regional MOH supervisors, who have full-time duties in district hospitals, such as chief OB/GYN, chief medical officer, or matron in charge of the maternity ward. AVSC's strategy in Kenya is to have these supervisors begin to visit other health care facilities in their districts? including missionary hospitals, private nursing homes, and NGO clinics, as well as MOH facilities? and take on the role of facilitative supervisor in planning training and/or certification, coaching, supporting, mentoring, and problem solving. Eventually, AVSC would like to demonstrate the effectiveness of these supervisory teams and persuade the MOH to assign a deputy public health nurse to serve in a primary role on the supervisory team.

5.2.5 Whole-Site Training

Whole-site training is an approach that encompasses a range of training strategies and methodologies designed to meet needs identified at a site through COPE and supervisory assessment, and sometimes by clients. In an AVSC background document and *AVSC Working Paper No. 8* (Jezowski et. al., 1995), AVSC describes whole-site training as emphasizing individual development and teamwork. Learning needs can be met through orientations, updates, or refresher sessions and skill training, which can be conducted on-the-job or off site. AVSC has used whole-site training in more than 15 countries, including Mexico, to expand vasectomy services.

The Tanzania review assessed experience with whole-site training. The review team observed or received information about on-the-job, site, and regional training. Staff and area supervisors offered evidence of more efficient service delivery and supervision following decentralized training. The report noted that a perception exists that OJT often requires more time for trainees to complete all required training and practical experience. Some staff interviewed noted that OJT, as currently carried out, does not always ensure the opportunity for didactic instruction as well as practical experience, and because of the concentrated time period for training, limits trainees' opportunities to share ideas, which is easier at centralized courses. The supervisory team noted that initially OJT had been "unstructured," but added that in the past year draft OJT guides have been developed to identify the knowledge, skills, and attitudes needed for specific training activities.

The evaluation team reviewed a copy of the draft OJT guidelines from Kenya. The guidelines refer the trainer to sections of standardized curricula to be used to transfer didactic and practical knowledge and skills. Each AVSC-facilitated site is being outfitted with a library that will include the curricula and other reference materials. The team verified the existence of the library at a private clinic included in the Kenya project. However, the team found the OJT guidelines sketchy and questions the feasibility and appropriateness of using standardized, centrally planned training curricula for an OJT session. The team has concerns about the ability of trainers to cover the didactic training sections during their regular workday or during a field visit (for an off-site trainer). The team also has concerns about the volume of patients in small sites, which will limit the development of skills competency for specific procedures.

The evaluation team reviewed costing tools that AVSC is using with counterpart organizations in Kenya to help facilities calculate the cost of specific procedures they provide. These tools are a first step to financial management and control and fee setting.[12] AVSC also helps counterpart institutions better manage their expendable supplies and equipment to conserve resources and provide services more effectively. Programs in Egypt, Eritrea, Ghana, India, Kenya, and Turkey have used the cost analysis methodology manual.

5.3 In-Reach

In-Reach is an intervention that uses a health facility's resources to improve understanding and knowledge of the facility's family planning or other reproductive health services. In-Reach addresses missed opportunities by providing information about a facility's services to staff, clients, and potential clients in all departments; improving linkages and referrals between departments; posting signs about services throughout the facility; and orienting staff from other departments to reproductive health services. Per *AVSC Working Paper No. 5*, "In-Reach: Reaching Potential Family Planning Clients within Health Institutions," combined data from two In-Reach study sites in Kenya showed increases in the number of postpartum clients who discussed family planning, heard a lecture, saw a poster, received a leaflet, or received a contraceptive method following In-Reach intervention.

The Tanzania midterm assessment reviewed In-Reach and revealed some variability in knowledge and application. In general, staff at public sector facilities working with the UMATI (supervisory) team better understood In-Reach's purpose and could provide examples of In-Reach activities. However, the review team determined that officials from the MOH, UMATI, and Marie Stopes and representatives from donor organizations were not familiar with In-Reach and could not provide examples of In-Reach activities that had been introduced in their clinics and hospitals. Nevertheless, in most facilities where In-Reach was conducted, both family planning

and non-family planning staff received updates and information on family planning and reproductive health. In some facilities, staff from MCH/FP units routinely visit other (non-FP) wards (female, male, pediatric, maternity) to help orient staff to services and to encourage referrals.

Staff participating in the study cited the following examples of In-Reach:

- Instituting a suggestion box for client input on services,
- Posting clear directions to MCH/FP units within a facility,
- Routinely conducting orientations on FP issues and services for non-FP staff,
- Training "ward training teams" in FP counseling for community outreach,
- Assigning FP counselors to other wards in some hospitals,
- Using the In-Reach technique to advise staff and clients of the benefits of breastfeeding,
- Placing clear instructions at registration regarding payment and directions to the cashier, and
- Providing training in malaria recognition and referral to all staff in one facility.

5.4 Training

Since its inception, AVSC has been a recognized leader in sterilization training. AVSC perfected and disseminated clinical training in minilaparotomy with local anesthesia and NSV. In the last Cooperative Agreement, sterilization training was a critical activity. More recently, AVSC has moved into other training areas in clinical methods and procedures, including NORPLANT, DMPA, postpartum IUD, postabortion care, infection prevention, contraceptive technology updates, and counseling. With the development of the quality approaches, AVSC has recently expanded training to include quality of care, medical quality assurance, and supervision. At the same time, it appears that training activities have become less focused. AVSC seems more interested in harnessing resources to work to improve service delivery systems using quality supervision, than in developing, systematizing, and evaluating training effectiveness.

To initiate training activities, AVSC collaborates with host-country institutions. With its counterparts, AVSC sets criteria for trainee selection but cannot always enforce this criteria. In some countries, training is used as a perk or incentive. In addition, local governments often give training slots to providers who will not be able to apply the skills after training. When working with public sector systems, this may be even more problematic. AVSC's COPE self-assessment exercise used to identify training needs at the clinical site and the on-site training strategy are attempts to address this centralized training problem.

In April 1997, AVSC drafted a comprehensive training desk reference for staff to use when assessing training needs and planning and evaluation training. The reference includes sections on adult learning theory, experiential learning, and competency-based training. This guide reviews the training process step-by-step and is designed for staff to use when developing their own training sessions. Table 1.3 in Appendix F lists training materials produced by AVSC during this Cooperative Agreement.

In 1995, AVSC developed an excellent counseling curriculum prototype containing three components: a trainer's manual, a participant's handbook, and a guide for health care providers. The curriculum is consistent with JHU/PCS's GATHER approach. This prototype has been adapted and modified for use in India, Kenya, and Nepal. Between 1993 and 1997, AVSC used this prototype to produce or help produce counseling training curricula for Indonesia, Jamaica, Mali, Senegal, Russia, and the Philippines. AVSC worked in collaboration with national programs to improve counseling services through training in Bangladesh, Bolivia, Colombia, Egypt, Ethiopia, Ghana, Guatemala, Guinea, Indonesia, Jamaica, Kenya, Kyrgyzstan, Mali, Mexico, Nepal, Nicaragua, Nigeria, Pakistan, Paraguay, Peru, the Philippines, Senegal, Tanzania, Turkey, Vietnam, Uganda, the United States, and Zimbabwe.

In India, in selecting participants for the first counseling skills training, AVSC tried to identify candidates who had potential to become trainers? either they had the right characteristics (e.g., empathy) or were in positions that would allow them time to train (e.g., posted at district hospitals). These trainees are observed and critiqued during the counseling training and during post-training practice (through follow-up). The follow-up reinforces and builds on the trainees' skills. The 10 trainees who have mastered the skills and have the potential to train others are trained as trainers through a TOT. AVSC then mentors these trainers through their first two to three training events. In two districts, AVSC has already successfully handed over training to these trainers.

"Talking with Clients about Family Planning" is an accurate and simply worded manual for providers with client information on methods, STDs and AIDS, and postpartum and postabortion contraception that can be used as part of the counseling curriculum or as a stand alone counseling reference. AVSC plans to update and revise the 1995 counseling curriculum prototype in 1998 to incorporate broader reproductive health modules and to strengthen current modules in postabortion, postpartum, and STD/HIV prevention.

The results of the survey of USAID missions indicated that several missions believe AVSC does not sufficiently follow-up and evaluate the impact of its training activities. The evaluation team reviewed one clinical training impact evaluation study that was very well done (Bolton, Eiseman and Landry, n.d.). This type of evaluation is very useful for identifying problems with training to address and modify training strategies. As discussed throughout this report, AVSC is experimenting with new training approaches, such as whole-site training and on-the-job training, to transfer knowledge and skills. To truly understand the effect and success of these new training models, more rigorous and systematic evaluation is needed. Generally, 10 percent of training funds should be used to evaluate training. Without adequate evaluation, ineffective training strategies continue.

During this Cooperative Agreement, AVSC conducted counseling training evaluation in 12 different studies. Most included counseling skills observations. Recent country evaluations in the Central Asian Republics, Colombia, Mexico, the Philippines, Russia, and Ukraine documented the positive impact of counseling training on service providers' attitudes and skills and on an improved client orientation to service delivery (AVSC background study).

5.5 Medical Monitoring Tools

AVSC uses several monitoring tools to observe clinical procedures during site visits. These instruments encourage a systematic and objective observation of clinical skills and practices to ensure safe and quality patient care. The tools are designed to observe NORPLANT, vasectomy, minilaparotomy, and infection control and asepsis practices and procedures.[13] In the past, AVSC staff and external consultants performed medical monitoring using these tools. In several countries, AVSC has hired clinical staff to perform this function. AVSC seems to be concerned that these tools are "inspectional" and don't foster a supportive supervision style. However, the evaluation team supports the use of such tools. The use of these tools will ensure standardization in the quality of practice for specific procedures. Although there is a certification process based on observation, such as the one used in Kenya, careful use of medical monitoring tools will provide a second quality check when several iterations (second or third generation) of OJT occur. Such standardization is particularly important because, as previously mentioned, the observed

OJT curriculum appeared weak and not designed for an OJT training strategy, and training follow-up did not appear systematic.

5.5.1 Quality Improvement Assessment Checklist

The quality improvement assessment checklist (QIAC), which consists of 10 checklists, is a management and evaluation tool for supervisors to identify problems and measure changes in the quality of services using indicators based on clients' rights and providers' needs. A total score and percentage is calculated for each indicator. By gathering data annually, supervisors and sites can monitor the improvement of service quality at the site. In addition, supervisors are able to identify problems that exist across sites. The tool is being pretested in Tanzania. AVSC used the tool as a baseline in 58 sites with a one-year follow-up to measure changes in the service quality. In May 1997, follow-up data was available for 43 sites, but at the time of this evaluation, the data was not yet available for the team to review follow-up application in the same sites.

5.5.2 Quality of Care Centre Monitoring Checklist-Nepal

The quality of care (QOC) team in Nepal developed a basic quality checklist that assesses infrastructure, equipment, supplies, training, and infection control procedures. The field supervisor uses this checklist during periodic visits to clinical sites to identify quality concerns and help staff improve their services. The QOC team tracks sites through their information system and can show changes in quality at specific sites. Once most of the sites have achieved a basic level of quality, the QOC team plans to add new components, such as counseling, to the checklist to begin to address some of the more intermediate quality issues.

5.5.3 Medical Quality Assurance Guidelines

Results from the USAID mission survey indicate that AVSC has had an impact on national reproductive health guidelines, policy, and regulatory practices in Egypt, Bangladesh, Nigeria, Tanzania, and Uganda. Also, AVSC has developed training materials for more than 10 countries, and global training materials for minilaparotomy have been adapted by programs in Bangladesh, Egypt, Mexico, Nepal, the Philippines, and Turkey. Table 1.2 in Appendix F lists standards and guidelines that AVSC has developed or assisted in developing. In general, AVSC has not systematically assessed the impact that these materials have had on the quality of service provision; however, the AVSC-funded QOC management team in Nepal monitors sites to ensure compliance with the standards that AVSC helped develop. In their site visits, the evaluation team noted changes such as better waste disposal, improved follow-up and reporting of complications,

more consistent high-level disinfection and autoclaving, and hemoglobin testing for all minilaparotomy patients. As a result of this work, AVSC received reports on complications in sterilization related to laparoscopic procedures. In all countries where AVSC works, mortality related to sterilization procedures is tracked. In Kenya, AVSC conducted and published a 15-year study on sterilization complications. However, morbidity and infection rates related to permanent and long-term methods are not consistently tracked.

5.6 Policy

Because AVSC is a service delivery agency, it is difficult to determine how much effort should be devoted to policy. In many cases, policy change is better initiated from within a country; outside organizations, such as AVSC, may not always be well received when they try to influence national policy. Nonetheless, there is still an important role for global organizations such as AVSC that are respected among providers and have unique access to influential leaders within the MOH or even particular hospitals or clinics. For example, in Kenya AVSC has developed a credible voice on clinical quality and safety and assisted in developing policy guidelines on reproductive health. In Nepal, AVSC assisted the government in improving the reproductive health policy environment by creating a matrix that revealed gaps and inconsistencies in policy and highlighted conflicts between policy and program priorities. Also, AVSC gains special access to Nepali policymakers twice a year when it presents quality of care orientation. These orientations allow AVSC to authoritatively explain and defend new policy guidelines that may be approved by the MOH.

Although a policy may change officially, doctors' personal views or simply a lack of information about the policy change may perpetuate a de facto barrier. AVSC has the opportunity to address such barriers through its input into the training of doctors, other service providers, and their trainers. For example, the AVSC/Kenya program successfully used on-site orientations in many areas to address barriers related to spousal consent for sterilization. This type of follow-up and monitoring is essential to ensuring that new guidelines are implemented at all service delivery levels.

Another area that deserves special mention is AVSC's behind-the-scenes work to encourage the Government of Nepal to reconsider its current incentives and rewards program, which includes financial incentives for providers based on the number of sterilizations performed. AVSC has assessed the policy climate and wisely determined that a quiet course of persuasion is the most effective tactic. This area deserves continued focus. Additionally, AVSC is encouraging USAID to consider if its role is influencing the target mindset.

AVSC has also made important global policy contributions beyond the country-specific

examples. For example, AVSC produced a report on the "metering restrictions" of USAID population funds and how these provisions negatively impact program management and services. AVSC's work on free and informed choice is also noteworthy. For example, AVSC demonstrated global leadership in the mid-1990's when concerns were raised about the safety, effectiveness, and consent problems surrounding quinacrine. AVSC held a meeting of experts to discuss these issues and then published a working paper in July 1994 that summarized the opinions and recommendations made at the meeting.

Conclusions

In COPE, facilitative supervision, and OJT, AVSC has developed and marketed simple, common-sense tools to improve performance and service delivery. Many other CAs are working in quality improvement and assurance and have developed instruments, exercises, and tools to improve services, but COPE is the only quality tool that is a self-assessment tool used with clinic providers to improve service delivery. Facilitative supervision, AVSC's term for good supervision, emphasizes the obvious: good supervision is essential to consistently high performance. Supervision is the oldest and most written-about management skill; in *Manage People Not Personnel: Motivation and Performance Appraisal* (1981), Wickham Skinner writes: "The importance of good supervision is so obvious that its rarity is astonishing. "Enabling, supportive, facilitating supervision stands apart from the infrequent, inadequate, and sometimes punitive supervision that developing country providers often receive after centralized training. More good supervision is urgently needed, and AVSC should be commended for recognizing its importance and making it a cornerstone of their program. Those providers who participated in AVSC's facilitative approach attest to the difference in their outlook and behavior.

However, the evaluation team is concerned that in an attempt to cover a system or a large number of geographically disperse clinic sites (as in Kenya), AVSC is turning over to counterparts full responsibility for these approaches before sufficient institutionalization has been achieved. Institutionalization is often defined as "building relationships or patterns of importance in the life of a community or society or to make into or treat as an institution." Institutionalization connotes that an organization or institution has come to "buy into," own, and be committed? over the long term? to new ideas, approaches, and standards. Institutionalization is a key element of sustainability; institutionalized approaches are likely to be sustainable because people will value them highly and will struggle for the resources to continue them. This paradigm of institutionalization and sustainability is consistent with AVSC's. An AVSC internal discussion document on sustainability highlights the importance of ownership and reflects AVSC's attempt to define its role in promoting sustainability. It also acknowledges AVSC's need to develop and apply process indicators and benchmarks.

The evaluation team urges AVSC to begin this work in earnest. At issue is the quality of training, monitoring, and follow-up that will occur when AVSC has "scaled-up" with public sector institutions by delegating greater responsibilities to local counterparts that are already overwhelmed by myriad tasks and responsibilities as well as a lack of resources. The evaluation team doubts that institutionalization of commitment or skills has occurred at the larger Kenyan sites they visited. At the MCH unit of the large MOH Nyeri Hospital, COPE was a one-time exercise undertaken several years ago and there is apparently little memory of the event. At a busy CHAK hospital where COPE had been undertaken at the MCH ward, the hospital administration had not participated or apparently bought into the process. COPE, like other continuous quality improvement tools, demands time and commitment from management and staff. COPE facilitation is a complex skill that takes time and practice to achieve competency.

Institutionalization, an AVSC goal, means that the newly introduced problem-solving approaches, recently applied to issues under AVSC's facilitation, can be continually applied to new and potential problems without AVSC's facilitation.[14] AVSC recognizes that institutionalization of quality improvement approaches is more difficult in the public sector than in the private. In *Studies in Family Planning*, AVSC wrote of its lessons learned in 1993:

> After conducting follow-up visits and COPE exercises at more than 50 sites, AVSC has learned that COPE is most successful where staff are enthusiastic, dedicated, and able to look at their performance honestly; where the administration is interested, active and supportive; and where staff have more control over resources, as in non-governmental organizations (Lynam et. al., 1993).

AVSC has several innovative clinical and nonclinical training strategies including on-the-job training and whole-site training. They have developed a training reference manual for staff to standardize and improve the quality of training. Also, they have conducted some clinical training impact studies and have conducted more numerous evaluations of counseling training. In the new corporate team structure, AVSC evaluation staff will be able to work with program staff early in the planning process to incorporate evaluation into the programming and training activities, addressing USAID missions' comment that AVSC has paid insufficient attention to training follow-up and evaluation.

The evaluation team suggests that OJT receive special attention to verify both the quality of service rendered by providers and the volume of service providers trained in OJT. To transfer the skill, on-site practitioners are usually used as trainers; off-site supervisors, qualified to certify the trainee, then observe the skill for certification. As mentioned, off-site supervisors in Kenya are often busy practitioners who work in high-volume, resource-poor institutions with myriad manpower, supply, and equipment shortages. The volume of specific procedures performed in

small clinical sites may be so sporadic that training takes place over long stretches of time while staff has changed. Conversely, in locations where a high volume of procedures are performed, busy practitioners may not have time to review the didactic and theoretical knowledge needed for effective skills transfer. In Kenya, many trainees urgently need to be trained in specific procedures; on-site training is time consuming and probably not the best strategy for addressing such backlogs.

AVSC has successfully packaged, documented, and marketed their quality improvement approaches. Now, before scale-up, is the time to rigorously evaluate them. Past evaluations of COPE and facilitative supervision have been process-oriented, qualitative, and anecdotal. With COPE, AVSC has based most of its findings on post-COPE interviews with providers and, in some cases, clients. With facilitative supervision, AVSC has relied on interviews with supervisors and their staffs. More work is needed to objectively and verifiably measure changes in providers' attitudes or behaviors, client satisfaction, and service statistics at facilities that have used COPE. Such work will demonstrate more rigorously how and when these are effective approaches to improve quality and increase use of reproductive health services in large public sector systems. More work is needed on facilitative supervision, the newest of AVSC's quality improvement approaches. Although use of this method makes sense intuitively in NGOs where there is greater management control, more information is needed to determine under what circumstances it is appropriate and effective in large under-funded, overwhelmed public sector systems. Before several countries attempt to scale-up this approach to larger public sector systems, more rigorous evaluation should be conducted.

AVSC medical monitoring tools are extremely useful for monitoring the quality and effectiveness of AVSC's approaches. The tools are useful for objectively and systematically observing procedures and identifying problems. In Nepal, in sites that receive visits from the QOC team, quality is being monitored over time so that improvements can be tracked. The QIAC is being used in Tanzania to measure quality changes in sites at baseline and after the intervention of the quality improvement package. The facilitative supervisory tools are in the early stages of development.

The team found that AVSC invests an appropriate level of effort in policy, given that AVSC is primarily a service delivery assistance organization.

Recommendations

7. AVSC should closely examine its strategy with COPE in large system scale-up. AVSC staff should cofacilitate COPE sessions, training, and coaching counterpart staff until they

are competent to facilitate on their own. (Recommendation #11 in Major Conclusions and Recommendations)

8. AVSC should work with the Population Council Operations Research Project (FRONTIERS) and/or FHI to design and conduct an evaluation study to rigorously show the effects of the COPE exercise on changes in providers' attitudes and behavior, client satisfaction, quality of service, and service use. (Recommendation #10)

9. AVSC should design pilot projects with intensive, rigorous evaluations of facilitative supervision in countries such as Tanzania, Kenya, and India. These studies should examine in an objective and verifiable manner the impact of the approach on quality of services and method mix. Only after such evaluations should AVSC scale-up the model to wider geographical areas. (Recommendation #12)

10. AVSC should develop curricula for transferring specific knowledge and skills that are consistent with an OJT training strategy. AVSC should review the implementation of OJT in the Kenyan program (and in other countries) to ensure that OJT guides, curricula, and skills competency training are appropriate, observed, and systematically applied. A special evaluation study should compare the effects and outcomes of this approach with more traditional models. AVSC should be systematic in its use of on-site training; careful oversight and monitoring of this strategy should be conducted in small pilot sites with appropriate evaluation of the training strategy's impact. Strategies to address training needs should be carefully selected, with central training considered as an option where appropriate. (Recommendation #9)

11. AVSC should encourage the use of the medical monitoring tools by "facilitative supervisors" to ensure quality, systematization, and standardization in skills transfer and application. AVSC should ensure that as responsibilities for monitoring and supervising are turned over to counterpart supervisors, the tools are routinely used to monitor the quality of medical procedures. AVSC/Nepal should continue to track quality with the monitoring tool and develop new sections of the tool as they begin to increase their focus on quality of counseling and client/provider interactions. The weighting of the different components of the tool should be assessed. The tool developed in Nepal should be shared with other AVSC offices. (Recommendation #15)

12. AVSC should devote resources to evaluate training impact in a more systematic and routine manner as a part of the training design. Ten percent of most training budgets should be dedicated to training evaluation. (No corresponding Recommendation)

6. ACCESS AND UTILIZATION

6.1 Access

Access is an important output measure of service delivery. In the "Handbook of Indicators for Family Planning Program Evaluation," Bertrand et. al. define access in five dimensions: geographic or physical, economic, administrative, cognitive, and psychosocial. In varying degrees, AVSC's program and strategies address all of these dimensions.

6.1.1 Geographic or Physical Access

In the last Cooperative Agreement, AVSC shifted from working with a few clinical sites to working with larger public sector systems. This shift, more than any other factor, has increased AVSC's ability to provide geographic access to more potential clients. AVSC's provider clinical training in permanent and long-term methods creates increased client accessibility to services by increasing the number of sites and providers that can competently offer methods and services. Training physicians to perform minilaparotomy with local anesthesia and NSV and training nonphysicians to insert NORPLANT or IUDs and to inject DMPA increases the outpatient potential for availability of these services at the secondary and sometimes primary care level.

AVSC has many examples of expanded geographical access. In the Philippines, AVSC is working to ensure that sterilization services are available in at least 75 local government units (LGU) by setting up service sites in at least two hospitals in each LGU and training a team of service providers at each site. In Uttar Pradesh, India, and in Nepal, AVSC has been training providers at static sites to ensure that services are available year round instead of only seasonally in sterilization camps. In Uttar Pradesh, AVSC is training medical officers and auxiliary nurse midwives outside of the district hospitals at the secondary and primary levels to deliver family planning services and counseling to improve access to services at the village level.

In the Central Asian Republics, AVSC has had an important impact on the availability of services, as indicated by the declining number of abortions being performed and the changes in method mix after providers have been trained in family planning service delivery and contraceptive technology.

In Kenya, AVSC is training providers at the health center level and advocating changes in government policy to allow nurses to insert NORPLANT. Also, AVSC staff in Kenya is engaged in an important access versus quality debate. For example, although the MOH plans to train

nurses in health posts to insert IUDs, AVSC does not believe that the service could be safely delivered at that level because of high rates of RTIs/STDs, lack of provider training, and problems and limitations in RTI/STD screening.

AVSC's involvement with the public sector and quality improvement approaches is new in Kenya, while in India, AVSC has just recently begun working with the public sector. The evaluation team has concerns about AVSC's ability to scale-up to larger geographic areas by not directly performing training and monitoring, but by developing resources, such as trainers and supervisors, to perform these functions. In Kenya, the team observed that systematic supervision, monitoring, and follow-up had not occurred in some public sector institutions after responsibility for these functions had been fully absorbed by the MOH.

6.1.2 Economic Access

As a service delivery technical assistance CA, AVSC has focused less on issues of economic access. However, one might suggest that AVSC's shift during the last Cooperative Agreement to working with MOH institutions rather than NGOs has indirectly increased economic access for the poor, who generally access services in greater numbers through the public sector. AVSC has worked with some counterpart institutions to increase their awareness of service delivery costs.

6.1.3 Administrative Access

AVSC programs and approaches, such as COPE and In-Reach, seek to address barriers to administrative accessibility by identifying problems and finding solutions. For example, in one FPAK clinic a COPE CFA found that the staff took their tea break at the same time that clients experienced long waiting times for services. After identifying this problem, the staff agreed to stagger their tea breaks to better serve their clients' needs. Furthermore, some clinics have altered their hours of operation based on feedback from the client survey section of the COPE exercise.

6.1.4 Cognitive Access

AVSC's In-Reach seeks to eliminate "missed opportunities" for service delivery. Furthermore, signs are placed throughout clinic facilities to direct patients to family planning and other reproductive health services. The health facility will hold orientation sessions to make staff aware of the facility's family planning and reproductive health services and methods and ways to access them, so that staff may better inform and direct facility clients. On the macro level in

several countries where AVSC has worked, prospective users' knowledge and use of vasectomy and minilaparotomy has increased. In Tanzania and Kenya, knowledge rates of vasectomy have increased greatly; in Kenya, use of female sterilization has increased dramatically; and in Mexico, knowledge and use of sterilization have increased.

6.1.5 Psychosocial Access

AVSC's programs identify and address psychosocial accessibility by focusing on clients' needs and rights. This focus stems from AVSC's tradition of ensuring informed consent for sterilization procedures, including providing method choice and quality information, examining client perceptions, and providing quality counseling that addresses the individual's concerns. AVSC has conducted research on client perceptions of sterilization in India, Mexico, Nepal, and Sri Lanka. In Uttar Pradesh, a study examined whether clients would seek services from a male physician.

6.2 Utilization

The current Cooperative Agreement does not require AVSC to keep service statistics. Service targets, presented in AVSC's logical framework of their proposal for this agreement, have been dropped. However, the Cooperative Agreement language and mission cables clearly indicate that USAID expects use of permanent and long-term methods to increase as a result of its funding AVSC. The Cooperative Agreement states

> AVSC has submitted a proposal which calls for doubling their efforts in the first five years to include all long-term contraceptive measures including sterilization, IUDs, NORPLANT, and injectables such as Depo-Provera. By doubling the size of the program, AVSC expects to more than double the number of sterilization procedures in the countries that they are working in.

According to AVSC, collecting service statistics data from NGO and public sector clinical sites is problematic. Weak and nonexistent management and health information systems, client record keeping, lack of standardization in reporting, and underreporting are just some of the obstacles to collecting reliable statistics on a routine basis. In the past, AVSC has worked through subagreements, making direct cash grants to host-country counterparts for specific projects; this arrangement made it easier for AVSC to require that statistics be included in routine reporting. As mentioned, AVSC is moving from project assistance to a more program-oriented approach, increasing its portfolio to include large public sector systems and moving to a technical assistance role. This new role and the work with public sector systems makes collecting service statistics data even more problematic. AVSC does collect utilization data for some

subagreements, but does not have data for the institutions for which they only provide technical assistance, an increasingly frequent programming approach.

Additionally, AVSC points out the difficulty in giving credit for changes in population data? such as increases in contraceptive prevalence? to their programming when other CAs and even other donors are working in the same country, region, or sometimes the same facility. Furthermore, AVSC's quality improvement approaches, which seek to empower and transfer skills and ownership of a program to local counterparts, make ownership, control, and collection of this data even more difficult.

In the 1991 evaluation of the previous Cooperative Agreement, the evaluation team found that program impact data were not being collected and recommended that AVSC "accelerate efforts to measure the quantitative impact of its programs, VSC procedures, and demographic events."

Conclusions

Of the five access dimensions, AVSC addresses four of these dimensions directly and one indirectly. Geographic and physical access is addressed through clinical and nonclinical training and through work with public sector institutions. Economic access is not directly addressed through AVSC programs, but it may be indirectly affected through work with public sector institutions that serve the poor. Administrative and cognitive access are affected through the quality improvement package components of COPE, including CFA, client surveys, and In-Reach. Psychosocial accessibility is addressed through counseling and client-focused research.

AVSC does not currently measure accessibility to services or the impact of increases in accessibility beyond output measures, such as the number of providers trained in clinical and nonclinical methods, COPE sessions and follow-up sessions held, In-Reach activities conducted, or client-focused research projects conducted. Beyond these output measures, much of the available data about increases in accessibility are qualitative or anecdotal.

The collection of routine service statistics in clinical service delivery sites is also problematic. As AVSC has moved from a project approach to a programmatic and technical assistance approach and has moved away from working with small numbers of NGO or public sector sites to working with public sector systems, data collection has become even more difficult. Although measuring changes in service use and impact are difficult and expensive, the task is not impossible. As population funds become more competitive, there is an increasing need to show results and impact.

Recommendations

13. AVSC should use more systematic indicators for measuring increases in accessibility and impact on service utilization. AVSC should build service statistic collection into the program design at the beginning of the program (baseline) so that country evaluations can obtain relevant service statistics to better assess the progress and effectiveness of strategies. (No corresponding Recommendation)

14. AVSC should adopt a list of ten key results with specific impact-oriented indicators to show the results of their technical assistance. (No corresponding Recommendation)

7. CLIENTS AND CUSTOMERS

AVSC is one of the strongest CAs in its customer orientation and client focus; clients are at the center of its programming framework and its quality improvement package has many components to use client feedback to improve service. AVSC has a strong research capability to examine clients' needs and perceptions and it is moving toward a more participatory approach to involve clients in the design, implementation, and evaluation of program approaches and country programs.

7.1 Clients' Rights and Needs

AVSC uses IPPF's principles of clients' rights and needs as a foundation for programming and improving service delivery. COPE client surveys and client-focused research raise policymakers and providers' awareness of clients' perspectives. AVSC conducts global leadership and policy dialogues on issues related to clients' rights and needs, serving as a leader with other CAs. Results from the surveys conducted of other CAs for this evaluation indicate that AVSC is a recognized leader in this area.

The COPE exercise uses client surveys to make providers aware of clients' rights and needs. AVSC has produced numerous special studies on client perspectives, including the following:

- Nepal-sterilization;
- Nepal-clients' perspectives on quality and psychosocial barriers to accessing services;
- India-sterilization study exploring the importance of the gender of the provider; and
- Worldwide, routine client exit interview studies in country program evaluations.

7.1.1 Informed Choice

Attention to free and informed choice has been a cornerstone of AVSC's work for more than fifty years and AVSC is a recognized leader in this area. The AVSC Background document states

During medical site visits, AVSC staff and or consultants routinely conduct a review of the records of a minimum of ten clients who have recently undergone sterilization procedures. Site visitors review informed consent forms to ensure that they have been signed and are in proper order. The Medical Monitoring Handbook includes a sterilization record review checklist to assist in this review. The Medical Coordination Manual includes guidelines about counseling and informed choice issues which site visitors should address. In addition, during these visits, site visitors try to observe counseling to assess informed choice issues. All site visitors are required to submit trip reports that describe findings and recommendations. In July 1997, AVSC conducted an update for its medical staff on informed consent and counseling issues during a medical staff workshop.

AVSC commissions audits, for all subagreements valued at more than $25,000, within six months after the end of the agreement. The auditors are required to not only conduct a financial audit but also to audit sterilization client records to ascertain if the institutions are complying with the standard provisions for informed consent. These findings are included in all final audit reports of service delivery subagreements.

Every year AVSC prepares a voluntarism review of issues, which is included in its annual evaluation report to USAID. The purpose of the report is to document what they have done (activities, products, research) to bolster informed choice, identify issues that emerge from programs, review how our systems are working, and make recommendations for areas of improvement.

In the fall of 1997, AVSC will conduct a special review of policies, management procedures, and staff orientation in the areas of informed choice and informed consent for sterilization. This is a practice dating to the mid-1980's, when agency policies, protocols, and grants management procedures were established, informed guidelines were written, and staff development workshops on voluntarism were conducted on a periodic basis.

A new program team? Advances in Informed Choice? developed a workplan to address informed choice and protect the "voluntary" in voluntary sterilization and other clinical procedures in 1997. The team will also address how to operationalize a broader concept of informed choice by examining its role in other reproductive health services.

In 1996, AVSC began a special case study on family planning consent for sterilization in Mexico. They are working with the Instituto Mexicano de Seguridad Social (IMSS) to document informed consent procedures with male and female sterilization clients. AVSC is exploring the meaning and utility of informed consent for sterilization from the perspective of clients, service providers, and policymakers, and to identify service delivery factors that support or threaten informed consent for sterilization from the perspective of clients, service providers, and policymakers, and to identify service delivery factors that support or threaten informed choice (IMMS and AVSC 1996). One focal point of the research is to determine what clients understand about the reason for, and content of, informed consent for sterilization, and what they would need to know in order to make an informed choice. There is some concern in Mexico that women may be pressured to accept contraceptive methods, without fully understanding their options. A secondary focus of this study is to identify possible barriers to informed choice for postpartum women who receive sterilization services. Findings of this study will be available in early 1988.

AVSC reports that "overall the number of allegations of voluntarism abuse related to sterilization have dropped sharply since the 1980's, with no cases reported from 1993 to 1995 in AVSC-supported programs." AVSC's programming focus has broadened to include the full range of contraceptive methods, as well as other reproductive health services, raising a variety of issues of informed choice. These include a lack of access to a reasonable mix of methods; provider bias and misinformation about postpartum and postabortion family planning services; provider reluctance to discuss common side effects during family planning counseling; lack of knowledge and skills for identifying clients at risk of STDs; and lack of access to reproductive health services.

Numerous barriers may exist in a given country that impede an individual's ability to make informed choices about reproductive health. These include government or donor imposed policies such as incentives and targets; provider or government bias toward or against particular procedures or contraceptive methods; absences of a reasonable range of contraceptive choices; sociocultural factors such as gender roles, general discrimination, violence or abuse; and, denial of information or services on the basis of personal characteristics such as age, marital status, religion, ethnic background, or gender. AVSC continues to work with governments and donors to identify and overcome barriers such as these.

In the future, AVSC plans to address critical issues and challenges in policy and counseling for informed consent. AVSC works with governments, such as those in India and Nepal, to remove incentives and other policy initiatives that may impede free and informed choice. As AVSC moves into a technical assistance role and as many government systems decentralize, AVSC will need to test new strategies to ensure functioning and effective informed consent policies. AVSC will facilitate high-level dialogue about the practical impact of setting targets as national

programs reinstitute target setting. Also, AVSC will explore new strategies to solicit client feedback to avoid courtesy bias that often affects the data collected from client interviews. The evaluation team examined several vasectomy counseling sessions in Nepal. Although most sessions were of good basic quality, during one session at an FPAN clinic the provider did not know what to tell a client who asked if a vasectomy was easily reversible. The provider responded that it was easy to reverse. Both AVSC/Nepal and AVSC/New York corroborated that this was a common problem in informed choice counseling.

A client satisfaction survey on sterilization services in Nepal found that although 89 percent of the acceptors were satisfied with the method and 94 percent indicated that their spouses were in favor of the decision, only approximately 50 percent of the clients knew that sterilization was a permanent method (New Era, 1995). In that survey, interviews were held with 1,000 sterilization acceptors (500 male and 500 female), 9 program managers, 14 physicians, 72 paramedics, and 97 extension or outreach workers. AVSC accurately notes that Nepal is challenged by a budget-driven system that effectively sets targets and puts unhealthy pressures on service providers, including counselors. AVSC is working to improve counseling and subtly influence policies that motivate counselors to push certain methods.

7.1.2 Counseling

Since the early 1980s, AVSC's concern for free and informed choice for voluntary sterilization services has driven their efforts to establish and improve counseling. Since the late 1980s and through this decade, AVSC's counseling efforts have focused on a range of family planning methods; in more recent years, reproductive health care issues have been incorporated into AVSC's counseling efforts.

AVSC has developed an excellent counseling curriculum prototype that is modified and adapted for in-country use. AVSC is moving toward a participatory focus on design, implementation, and evaluation that will study and include clients' rights, needs, and perspectives. In countries such as India, Nepal, and the Central Asian Republics where little counseling was previously conducted, AVSC institutes counseling to improve quality and informed consent.

7.2 Customer Satisfaction

As mentioned, customer satisfaction surveys are a key element of the COPE exercise. Other strategies to elicit client feedback often result from the COPE action plan. Such strategies include client suggestion boxes in clinic waiting rooms. AVSC's evaluations of country programs usually include customer satisfaction surveys or some form of client feedback data collection. Also,

AVSC conducts extensive customer satisfaction research studies.

Conclusions

Despite the strong design and conduct of counseling training, the quality of information provision and nondirective counseling is impeded by the following obstacles:

- Cultural taboos that impede the open discussion of sexuality and reproduction,
- Provider discomfort and reluctance to ask questions that the client may find embarrassing or insulting,
- Lack of time for in-depth client counseling in busy clinics,
- Lack of privacy for proper counseling, and
- Lack of a correct vocabulary for discussing sexuality in terms that clients will understand.

Training follow-up by supervisors is key to building on the skills learned in counseling training and ensuring that concepts learned in formal training continue to be applied on the job. Many countries have a lack of experienced and skilled nondirective counselors to observe and critique new counselors. Improving counseling skills to the point at which a counselor is highly skilled is a lengthy process and needs continuing reinforcement.

AVSC's research and approaches to quality improvement have focused on customer satisfaction. AVSC has successfully incorporated the client's perspective into research and programming activities. AVSC must continue to ensure informed choice for clients by improving counseling through training and follow-up and by addressing barriers that inhibit free choice. As discussed in Chapter 4, one aspect of client satisfaction to which AVSC should pay greater attention is pain management during female sterilization.

Recommendation

15. AVSC should ensure that a counseling practicum observed by skilled and experienced counselors is a routine part of counseling training. AVSC should also ensure that a follow-up system is in place to continue work with recent counseling trainees by

observing their skills in client counseling sessions and reinforcing and building their skills. (Recommendation #14 in Major Conclusions and Recommendations)

8. RESEARCH

AVSC's primary mission is service delivery. AVSC conducts research, usually in collaboration with other CAs with specific service delivery mandates, to answer service-related or clinical/surgical questions when it can facilitate access to service delivery sites. AVSC espouses biomedical research that can be used to immediately improve services, such as the 1997 publication of a paper describing a portable steam sterilizer adapted to low-resource settings and used for IUD instruments and supplies. Another good example of the positive results of AVSC's research is minilaparotomy with local anesthesia. An early medical publication described the small number of basic surgical instruments needed to perform a tubectomy through a small incision. A subsequent journal article described a simple device to elevate the uterus and make the procedure faster and more comfortable. The AVSC staff quickly recognized the potential value of these practical advances to developing countries where the demand for services was high and medical personnel and infrastructure limited. AVSC's training and reinforcing of basic surgical skills and renovating of sites to make them suitable to conduct surgery led to the popular acceptance of tubectomy in many countries where AVSC-sponsored, USAID-supported projects were successful.

AVSC has increasingly refined and codified all aspects of superior care for minilaparotomy with local anesthesia. When carefully performed, such a surgical procedure is brief and delicate, requiring accuracy and attention to detail. AVSC has shown that this procedure can be taught and replicated by many dedicated providers in different parts of the world. This procedure includes the attributes of a surgical operation, such as informed consent with alternate methods of long-term contraception available for ambivalent clients, pre- and postoperative care of instruments and facilities, and meticulous attention to local anesthesia with verbal support. AVSC has led in developing and institutionalizing minilaparotomy with local anesthesia in many developing countries and has proven that the procedure can be performed safely and in accordance with the highest international standards.

AVSC has had similar success with NSV projects, which were initiated after its medical director verified the innovations in NSV technique made by a Chinese surgeon. After AVSC introduced the procedure 10 years ago, NSV has become accepted in the United States and elsewhere as a safe, technically refined operation performed under local anesthesia. NSV has a very low complication rate and has been taught successfully to urologists and general medical doctors throughout the world.

Postpartum IUD insertion is a third example of AVSC leadership. Seven years ago, AVSC's medical staff began to revive this technique, which had fallen into disrepute after an initial study

suggested that the expulsion rate was excessive for IUDs placed before hospital discharge after delivery. AVSC's medical director identified a Mexican physician who was having success with the insertions immediately after delivery. Further studies, sponsored in part by AVSC, verified the critical areas in insertion technique and timing of insertion, which have made the use of PPIUD successful in several countries. With increasing urbanization and the likelihood that more women will deliver in hospitals in developing countries, this simple, reliable procedure for long-term contraception will become more widely used.

By identifying and bringing to wide acceptance three innovative, long-term family planning methods, AVSC has made a significant contribution for a service delivery organization. As the population increases and the need for quality, long-term, modern family planning methods grows, AVSC's medical and administrative staffs can be expected to continue to demonstrate the vision and leadership shown repeatedly in the past two decades. The following section presents recommendations for further work.

8.1 Biomedical Research

8.1.1 Male Studies

In "Results of a Pilot Study of the Time to Azoospermia after Vasectomy in Mexico City," AVSC, FHI, and Mexican colleagues recently reported the results of a preliminary study to determine the time it takes sperm counts to diminish to the point of infertility and finally to azoospermia following apparently successful NSV (Cortes et. al., 1997). The long duration of time to azoospermia in a significant number of men following NSV suggests a larger and extended corroborative study is necessary. This study should comprise the following elements:

- Begin with a baseline sperm count before NSV, with continuing follow-up including variables such as age, prior known fertility, occupation, type of vas closure (electrocoagulation, fascial interposition, or silk tie) and additional evaluations of sperm viability such as sea urchin egg penetration.

- Examine the long-term failure rate for vasectomy similar to the CREST evaluation of the long-term failure rate of female sterilization, because the study in Mexico of 38 men reported an astonishing failure rate of 7.9 percent (3 men) with continuing fertile sperm counts.

- Be a transnational study, as one skilled Nepali vasectomist told the evaluation team that he had recently reoperated on seven clients with failed vasectomies.

Several of these cases apparently had only one vas ligated (the clients were not notified) and several were apparently spontaneous recanalizations.

- Include a further study of nonsurgical, percutaneous occlusive substances or devices.

8.1.2 Female Studies

Cancer of the uterine cervix is the most common cancer for women in developing countries. The prevalence of cancer and its precursors by age group and by subgroups—urban or rural, married or unmarried, parous or nulliparous—could be studied with the objective of defining high-risk groups and the age range of those with precancerous lesions. Appropriate, low-cost tests should be directed at those most likely to benefit. Cancer can only be prevented before it becomes obviously symptomatic by the occurrence of abnormal bleeding and visual identification of an ulcerated area on the cervix. At this juncture, the cure rate is only 80 percent with the most sophisticated X-ray therapy and/or extended surgery. The identification of serious precancerous lesions (or serious dysplasias) with the naked eye after appropriate and simple cleansing and preparation would lay the groundwork for the next innovative step, a simple, low-cost surgical method of eradicating the identified area. Generally, the part of the cervix where these abnormalities appear can be seen when the cervix is viewed with a vaginal speculum, such as would occur during the initial stages of a minilaparotomy.

8.2 Operations Research

8.2.1 Vasectomy

The following operations research (OR) projects on vasectomy would be useful:

- A study of the variables affecting NSV acceptance including the role of the site (hospital, local health center, unit specializing in the care of men, or hospital devoted to the general medical problems of men); the role of the provider (training, interest, and enthusiasm); and the role of IEC activities.

- A study of NSV providers after training regarding the quality of their site and their surroundings, the relationship of their workload to their expertise, and the overall need for refresher training and/or supervision.

- A study of how NSV practices are absorbed by seasoned clinicians in developing countries. For example, in Nepal a quality of care supervisor noted a tendency for some providers trained in NSV to revert to what was described as the "classic" vasectomy method. Presumably, they added part of the NSV mode to their original repertoire.

8.2.2 Postabortion Care

Two PAC-related, operations research (OR) studies are important. First, it is important to document the value of PAC in its care of incomplete and potential septic abortions, as well as in its ability to minimize blood loss often associated with neglectful or delayed care. If MVA is performed in an emergency room before admission to a hospital (as is done in Kathmandu's Maternity Hospital), one could document the reduction in number of women admitted to the hospital and the decrease in number of days the women remain in the hospital. Although it would be a difficult task, it would be significant to assess the savings in drugs used, especially antibiotics. Even more telling would be a study of the number of deaths from incomplete abortion in participating hospitals as compared with maternal deaths associated with obstetrical deliveries.

Operations research on paramedics' role in PAC would also be useful. In Kenya, the paramedics performing PAC evacuations were still learning the procedure and would need further supervision to gain confidence. With an appropriate protocol to screen women with incomplete abortion, PAC evacuations can be carried out by medical personnel other than physicians.

8.2.3 On-the-Job Training

A third essential focus of operations research should be OJT training. OR should evaluate proposed OJT for country-wide systems to see how much deterioration there is in technical and counseling quality as iterations progress and certification by supervisors replace whole-site training and facilitative supervision by AVSC representatives.

Conclusions

AVSC continues to manifest leadership and vision in evaluating new or improved products for immediate use in their clinical service programs.

AVSC has the capability to conduct OR and internal evaluations of their programs, such as provider and client behavior changes, contraceptive choices of women in PAC projects, and qualitative and quantitative evaluations of their quality improvement packages.

Recommendations

16. AVSC should collaborate on important NSV pieces of research: AVSC should analyze vasectomy failures in countries such as Mexico and Nepal where large-scale programs exist. AVSC should facilitate continued study of sperm formation and delivery after NSV in collaboration with FHI and in consultation with experts in human sperm physiology. (Recommendation #5 in Major Conclusions and Recommendations)

17. AVSC should undertake OR on the appropriate use of medical personnel other than physicians in the clinical treatment of incomplete abortion. Demonstrable success using paramedics would increase access and use of PAC. (Recommendation #6)

18. As noted in Chapter 4, AVSC should consult an OB/GYN analgesia expert to consider better pain management for minilaparotomies. OR should be used to evaluate whether such changes will result in an increase in minilaparotomy acceptors over time, especially if it is marketed as a technical advance as was NSV. (No corresponding Recommendation)

9. AVSC MONITORING AND EVALUATION

The long-term goal of AVSC's evaluation program is to ensure that AVSC has the capacity to plan, evaluate, and disseminate results for all programs and use the results to improve current and future programs. Specific objectives are to (1) establish a system with which AVSC can identify human resources needed to meet program development and evaluation needs; (2) establish a system whereby all programs are assessed in terms of achieving long-range and annual goals and objectives; (3) develop a plan for assisting program managers and team members in identifying lessons learned from all programs, and a plan for establishing mechanisms to share lessons learned from programs for internal and external customers; and (4) meet AVSC and USAID's corporate-level reporting requirements, ensuring that reporting takes place efficiently and on schedule. AVSC conducts program evaluations, training evaluations, and qualitative and process evaluations of their quality improvement approaches.

Each AVSC program is required to develop an annual workplan, as well as a long-term strategy. AVSC issues workplan guidelines on an annual basis to guide program staff in developing their fiscal year plans. The plans include program duration and long-range program goals, fiscal year objectives, activities, outputs, revenue sources and amounts, assumptions, issues, and commitments. The fiscal year workplan serves as a guide for AVSC activities throughout the year and a document against which AVSC can measure progress and achievements. In 1996, each country program completed an Annual Country Performance Review that reported on progress and issues related to those objectives put forth for fiscal year 1995 to 1996. AVSC conducts more in-depth evaluations of given country programs every two to four years. These in-depth, country-level evaluations are generally conducted by teams comprised of AVSC staff or of AVSC staff and consultants. These evaluations generally involve reviewing documents; collecting service statistics and other related quantitative data; conducting interviews with in-country counterparts, administrators, providers, and clients; and observing clinical and counseling services.

Only 5.2 percent of the fiscal year 1997 budget is devoted to the goal of knowledge management of which evaluation is a component. The evaluation budget at the central level is only 1.6 percent ($454,655) of the total fiscal year 1997 budget.[15]

Conclusion

Country evaluations conducted by AVSC measure progress against objectives. The annual performance review serves as a regular monitoring exercise. AVSC has designed and will soon have functioning an integrated management information system (IMIS) whereby field offices can

enter their reports and workplans directly into the system to maintain up-to-date information. AVSC has also recently developed a bulletin board for staff throughout the world to share lessons learned and best practices.[12] The team reviewed several in-depth country program evaluations, which were good country reviews assessing current performance and future critical issues.

AVSC country evaluations, however, serve more to monitor progress than to evaluate the impact of specific strategies and interventions. Service statistics and other quantitative data were not always readily available for use in the country program. Although the Cooperative Agreement began with one service utilization indicator, this indicator has been dropped. Currently, the Cooperative Agreement has only process indicators with no impact, outcome, or service statistic data requirement.

The past two evaluations of the prior AVSC Cooperative Agreements found that AVSC evaluation was weak and needed to be strengthened.[13] The 1994 Management Review did not include questions on evaluation; however, the 1990 Management Review wrote that

> AVSC needs to devote more attention to developing reliable methods that evaluate its success. A high priority for AVSC's work under the Cooperative Agreement should be to develop and test new ways of measuring performance. This should be done in collaboration with A.I.D. [USAID] (especially the new evaluation section in the Policy Division) and research-oriented cooperating agencies such as the Population Council and Family Health International.

Previous sections of this report specifically recommend better evaluation. Following is a summary of key points.

- AVSC should build service statistic collection into program design at the beginning of the program (baseline) so that country evaluations will be able to obtain relevant service statistics to better assess progress and the effectiveness of strategies. AVSC should strengthen their evaluation by developing results and indicators for measuring achievement that report service statistics, impact, and outcome data where possible. (Recommendation #8 in Major Conclusions and Recommendations)

[12] AVSC also has developed a website that receives many hits per day. Most hits are domestic and the majority are interested in vasectomy and contraceptive method information.

[13] The 1986 evaluation was carried out by Scott Edmonds et. al. and the 1991 evaluation was led by John Marshall. The 1991 evaluation stated "AVSC is unable to provide quantitative evidence of its impact, and A.I.D. [USAID] finds accounts of the qualitative effects of AVSC's activities unpersuasive."

- AVSC has developed several quality improvement approaches that together form a quality improvement package. To date, most of the evaluations of these approaches have been process-oriented, qualitative, or anecdotal. AVSC should invest in a rigorous evaluation of the quality improvement package that will show the effectiveness of the approach through impact assessment. Changes in both provider attitude and services received may be measured. Method mix, reproductive intentions, and/or discontinuance rates could be examined. The Population Council Operations Project and FHI have expressed interest in collaborating on this effort.

- In terms of the cost for core evaluation of programs, 1.5 percent of an annual budget is very little. AVSC must resolve to devote a higher percentage of its efforts to evaluation. Good evaluation can be costly in the short-term; however, professionals believe it is a wise investment as it leads to more efficient and effective programs. Knowledge on how, why, and under what circumstances AVSC approaches such as COPE, facilitative supervision, and OJT might be efficient and effective in the public sector would be valuable; but it is unlikely that individual missions would fund such evaluation. Therefore, higher levels of core funding for global evaluation are necessary. Moreover, for AVSC to evaluate and document achievement of the results recommended for the follow-on Cooperative Agreement, a larger core evaluation budget is necessary.

Recommendation

19. AVSC and USAID should make a higher level of investment in AVSC's evaluation of its programs. (Recommendation #7)

10. PARTNERSHIP

10.1 Other CAs

The team interviewed AVSC's main collaborators in the United States and in the field; most thought that AVSC collaborated well with other CAs. AVSC works with, among many others, FHI and Population Council on research, the Management Sciences for Health on management, and JHPIEGO on standards. Where AVSC's field mandates have overlapped with those of other CAs, as has occurred with PRIME in India and JHPIEGO in Nepal, AVSC has worked constructively to minimize overlap and duplication.

10.2 USAID

All staff from USAID missions or USAID/Washington that responded to the evaluation e-mail or met with the evaluation team indicated that AVSC was a critical contributor to their Strategic Objectives.

10.2.1 The Global Bureau

At the Global Bureau level, AVSC has principally contributed to *Strategic Objective 1: "Increased use of voluntary practices by men and women that contribute to fertility reduction."* Most activities contribute to either *Program Result 1.1: "New and improved products and approaches for programs"* or *Program Result 1.4: "Increased access to reproductive health services."* AVSC has led, participated in, and supported numerous USAID/G/PHN committees and task forces established to promote or examine new PHN initiatives, such as the maximizing access and quality of care (MAQ) initiative and male involvement efforts.[16]

AVSC has been responsive to recent changes within USAID. One critical way AVSC has been responsive is by diversifying its funding base. In 1992, USAID income was 90 percent of AVSC's total $17.9 million income; other income totaled $1.8 million. Although annual USAID income has fluctuated between $14.5 and $21.3 million since this Cooperative Agreement began, other income has risen steadily. In 1997, non-USAID income was 16 percent of AVSC's total income and in actual dollars, double that of 1992.

AVSC credits USAID core funding with its ability to leverage other funds. For instance, USAID core support enabled AVSC to fund staff for a Men as Partners program; these staff were able to develop program plans and promote them to other donors. In its background paper for this evaluation, AVSC indicates that the Men as Partners meeting held in Mombasa "and the interest and support of other donors would not have been possible without having had the seeding support from USAID core support under the central Cooperative Agreement." Conversely, AVSC's non-USAID income helps USAID. AVSC is able to use these funds for new areas not yet funded by USAID (postabortion care) or to work in countries not yet funded by USAID (Vietnam).

USAID/G/PHN has high praise for AVSC, as AVSC does for USAID/G/PHN. AVSC indicates that USAID/G/PHN has been supportive, responsive, and enabling, adding that USAID/G/PHN's attitude made the difficult metering process possible. USAID/G/PHN and AVSC are now trying to address an issue raised by the recent "definitization" of the current Cooperative Agreement. In that "definitization," the Office of Procurement (OP) deleted, without consulting USAID/G/PHN or AVSC, the provision in the Cooperative Agreement that gave AVSC 18 months after the project assistance completion date (PACD) to spend down subobligations (subagreements). With less than a year remaining in the Cooperative Agreement, USAID's Office of Procurement changed the 18-month period to 3 months.

10.2.2 Missions

The majority of missions indicated that AVSC is very responsive to their priorities and to their Strategic Objectives. The team's analysis of AVSC's program and the Strategic Objectives of missions in Kenya, India, and Nepal confirms that AVSC tries very hard to be responsive.

11. THE FOLLOW-ON COOPERATIVE AGREEMENT

11.1 AVSC's Mission

As discussed in Chapter 1, AVSC has expanded its mission beyond clinical and surgical contraception and has secured several contracts to work in this broader arena. For instance, in Bangladesh in the large USAID-funded National Integrated Population and Health Program, AVSC is the prime contractor for the "Quality Improvement Partnership." Two subcontractors support this partnership: World Vision with child survival expertise and Concerned Women for Family Planning, a Bangladeshi NGO with local experience in reproductive health. In East Africa, AVSC has a contract with REDSO/ESA for quality management in child survival and nutrition.

11.2 USAID's Mandate for AVSC under the New Cooperative Agreement

Despite AVSC's expanded institutional mission, the evaluation team recommends that the mandate for AVSC in the follow-on Cooperative Agreement have, as its core, promoting access to and quality of long-term and permanent contraception methods. This recommendation is based on the following considerations.

11.2.1 Global and Country-Level Objectives and Results

To achieve its strategic objectives and results, USAID/G/PHN and mission staff identified a continuing need for a focused CA addressing unmet need for high-quality surgical contraception, including activities to promote access, improve quality, increase use, and understand national and global trends. Numerous staff (and other CAs) stressed the continuing need for a clinical leader? a CA that would lead the way in the future, as AVSC has in the past, with NSV and minilaparotomy.

At the mission level, AVSC has contributed to such objectives and results. For example, in India with $1.46 million field support funds, AVSC is helping to achieve a Strategic Objective of "*reduced fertility and improved reproductive health in North India*," which has, among five indicators, one method-specific CPR indicator and two fertility-related indicators. In the Philippines (project implementation order [PIO] of $1.8 million), AVSC is contributing to a Strategic Objective of *reduced fertility and improved maternal and child health*, specifically to the Intermediate Result of *expanding the delivery of FP/MCH services in the public sector*. One indicator of this intermediate result to which AVSC is linked is that *voluntary sterilization services must be available in at least 75 local government units*. Other missions noted similar contributions, specifically, in the areas of long-term and permanent methods, particularly VSC, medical quality, and general quality.

The majority of USAID respondents did not favor broadening AVSC's mandate to address broader USAID strategic objectives. They cited several reasons for continuing a mandate focused on clinical and surgical contraception. A principle reason cited by various missions was that expanding access to and quality of clinical and surgical contraception was such a large job that the addition of other activities might weaken AVSC's efforts toward that end. One mission, which highly praised AVSC's work, wrote "we feel that AVSC should neither expand nor diminish the roles, functions, and services that it is providing the country right now." One mission spoke of the immense task ahead in terms of expanding access to and quality of clinical and surgical contraception and indicated "we might just make it if AVSC stays the course." Other reasons cited by missions included competition with other CAs and duplication of effort.

There was, however, a minority opinion favoring an expanded mandate. Several missions indicated that AVSC is contributing to broader reproductive health strategic objectives, such as with Bangladesh's bilateral program. Several missions suggested that AVSC's mandate be expanded to include STD/RTI/HIV. A number of missions mentioned including postabortion care in the mandate.

11.2.2 Comparative Advantage

AVSC occupies a unique niche among USAID-funded CAs. USAID and other CAs recognize it as a leader in promoting access to and quality of long-term and permanent methods of family planning at tertiary and secondary service delivery points. Its long-term involvement with providing sterilization services and ancillary perioperative issues such as informed consent and infection prevention in the United States and the developing world has placed it in a unique position among family planning agencies. One mission that has invested substantial field support funds in AVSC's program wrote

> USAID believes that AVSC should concentrate its efforts on providing long-term and permanent methods in which they have over the years developed considerable expertise. Expanding to other areas in this country will mean duplicating the work of other CAs which is not in the best use of meager resources.

AVSC has led the way with NSV, minilaparotomy under local anesthesia, counseling and informed consent, and attention to clinical quality. AVSC understands itself to be, and is recognized by others as, the CA that has traditionally grasped new, underused clinical innovations, such as NSV, or new quality paradigms, such as Judith Bruce's six components of quality, and applied them at the service delivery level. AVSC has bridged innovation, research, and new paradigms with real-life clinical service delivery.

One can view AVSC's comparative advantage from three perspectives. The first is technical content, Graphic 1 presents AVSC's unique niche of promoting long-term and permanent family planning methods. The second perspective is activities undertaken to improve quality or increase access to those services. See Table 4, which identifies activities to plan, manage, and evaluate clinical services. In Table 4, activities considered by other CAs, AVSC staff, USAID, and the team to be areas of special AVSC competence are in italics. The third perspective is service delivery tier; AVSC works principally at the tertiary and secondary levels.[17]

Graphic 1

Table 4

A Checklist for Planning and Organizing Clinical Services

Activity**	Definition	Critical AVSC Competitor/ Collaborator
1. Develop Partnerships	Develop partnerships with host-country institutions and relevant donors	
2. Undertake Needs Assessment	*Undertake country/state needs assessment on specific RH services: identify potential opportunities, barriers (specifically gender), strengths and weaknesses; and investigate laws, legal issues, policies, and regulations regarding this service, again including gender*	JHPIEGO
3. Enable Support	Enable,obtain, and/or facilitate legal, formal, and information support for specific RH services	
4. Estimate Demand	Estimate demand (met and unmet) and caseloads at various service delivery tiers	
5. Develop Plans	Develop plans for generating demand and meeting supply: strategic, long-tern, operational, and financial	
6. Develop IEC	Develop IEC program for specific RH services	
7. Establish Service Delivery Policies	*Establish essential policies for specific RH services* C *Client-selection criteria* C *Procedures regarding free and informed decision making, counseling, and informed consent* C *Medical/surgical protocols and service standards* C *Infection prevention procedures and protocols*	JHPIEGO
8. Faciliate Clinic Infrastructure to Meet Client Needs and Provider Rights	*Facilitate/establish high-quality, client-oriented facilities: select, prepare, and renovate sites according to standards for specific RH services* C *Procure equipment, instruments, medicines, and supplies*	

	C *Establish storage and inventory systems*	

Table 4 (Continued)

Activity	Definition	Critical AVSC Competitor/ Collaborator
9. Facilitate Improved Human Resource Management and Development Systems	Ensure that clinics are staffed with enough technically competent, motivated, and supervised, client-oriented staff to serve client needs for specific RH services	PRIME
	C Determine skill requirements and undertake human resource needs assessment	JHPIEGO
	C Promote recruitment, selection, and deployment to meet client needs	FPMD
	C *Train and develop staff to meet client needs and ensure customer satisfaction*	QA Project
	C *Supervise and support staff to enable high-quality, client-centered service delivery*	Pathfinder
	C Motivate and compensate staff for high-quality, client-centered service delivery	CARE, etc.
10. Establish/Revise Client Systems and Client Materials	*Establish/revise systems, record forms, informational materials, etc. to meet client needs:*	
	C *Reception, intake, and registration (client flow)*	
	C *Record of patient history*	
	C *Clinic-based information activities*	
	C *Client counseling*	
	C *Informed consent*	
	C *Physical examination and medical screening, including laboratory tests*	

	C *Referral for medical or psychological indications or for other services* C *Preoperative preparation* C *Surgical procedure* C *Complications management and emergency treatment procedures* C *Postoperative monitoring* C *Postoperative instructions and discharge* C *Follow-up procedures*	

Table 4 (Continued)

Activity	Definition	Critical AVSC Competitor/ Collaborator
11. Institute/Revise Financial System	Institute/revise system for financial management and planning, including policies and procedures for costing and pricing relevant RH services	
12. Establish/Revise Monitoring and Evaluation System	Establish/revise monitoring and evaluation system designed to provide data for decision manking on specific RH services	
13. Research	Undertake research to make services safer, more effective, more efficient, and more client focused	Population Council, FHI

* Adapted from *Female Sterilization: A Guide to Provision of Services*, World Health Organization, Geneva, 1992.

** All activities are done with partners.
AVSC niche (unique expertise) activities as defined by AVSC or attributed by others are in italics.

11.2.3 Limits on Resources

The many missions that favored a continued focus on surgical contraception expressed the fear that an expanded mandate would distract AVSC from the current job at hand; in this case, it was a concern about limits to AVSC's resources. Other missions wrote or spoke about USAID's limited resources; these missions saw an expanded mandate as overlapping and inefficient.

11.3 Conclusions: Priorities, Results, and Indicators under the New Cooperative Agreement

THE EVALUATION TEAM SEES THE FOLLOWING AS PRIORITIES FOR THE NEW COOPERATIVE AGREEMENT:

- CONTINUED EFFORTS TO INCREASE THE AVAILABILITY OF AND ACCESS TO HIGH-QUALITY CLINICAL FAMILY PLANNING SERVICES (LONG-ACTING AND PERMANENT METHODS);
- MORE ATTENTION TO NSV EXPANSION;
- MORE PARTNERING WITH OTHER CAS IN RESEARCH FOCUSING ON PERMANENT METHODS;
- BETTER EVALUATION OF AVSC'S WHOLE PROGRAM (USE OF CORE FUNDS FOR COUNTRY-LEVEL EVALUATION);
- TESTING AND EVALUATING IN THE PUBLIC SECTOR SUCH HRM TOOLS AS ON-THE-JOB-TRAINING, COPE, AND FACILITATIVE SUPERVISION BEFORE THEIR SCALE-UP IN THE PUBLIC SECTOR; AND
- CONTINUED AVSC LEADERSHIP.

THE FIRST FIVE BULLETED ACTIVITIES IN THE PREVIOUS LIST HAVE BEEN DISCUSSED IN THIS REPORT. LEADERSHIP HAS NOT BEEN AS THOROUGHLY EXAMINED, ALTHOUGH THE NEED FOR AVSC'S LEADERSHIP WAS BROUGHT UP FREQUENTLY OVER THE COURSE OF THIS EVALUATION. THE QUESTION IS "WHAT DOES LEADERSHIP INVOLVE?"

AVSC STAFF ASKED THIS QUESTION, WONDERING WHAT USAID EXPECTED OF THEM IN THIS AREA, NOTING THEY HAD CONTRIBUTED GREATLY IN MANY WAYS OVER THE YEARS, WERE VISIBLE IN THE

CA COMMUNITY, AND CONTRIBUTED TO OR LED MANY TASK FORCES OR COMMITTEES. USAID STAFF IN WASHINGTON AND IN THE FIELD, NOTING THOSE CONTRIBUTIONS, REPEATEDLY IDENTIFIED PROBLEMS ON WHICH THEY SOUGHT AVSC'S INFLUENCE AND EFFORT SO THAT THEY MIGHT BE RESOLVED. OTHER CAS PRESENTED VERY SIMILAR IDEAS OF WHAT AVSC LEADERSHIP SHOULD ENTAIL.

A DEFINITION OF LEADERSHIP THAT CLOSELY PARALLELS THE NEED EXPRESSED BY USAID AND OTHER CAS HAS BEEN PROPOSED BY RONALD HEIFETZ, A PSYCHIATRIST AT HARVARD UNIVERSITY. IN *LEADERSHIP WITHOUT EASY ANSWERS* (1994), HEIFETZ DEFINES LEADERSHIP AS "...INFLUENCING THE COMMUNITY TO FACE ITS PROBLEMS....PROGRESS ON PROBLEMS IS THE MEASURE OF LEADERSHIP; LEADERS MOBILIZE PEOPLE TO FACE PROBLEMS, AND COMMUNITIES MAKE PROGRESS ON PROBLEMS BECAUSE LEADERS CHALLENGE THEM AND HELP THEM DO SO."

THERE ARE MANY PROBLEMS TO ADDRESS. AVSC'S EXPERTISE IS CLINICAL AND SURGICAL CONTRACEPTION AND THE PROBLEMS COMMONLY IDENTIFIED BY USAID AND OTHER CAS WERE RELATED TO THAT EXPERTISE. SOMETIMES INNOVATION IS NEEDED TO SOLVE THE PROBLEM; SOMETIMES RESEARCH IS NEEDED TO SOLVE THE PROBLEM. ALWAYS, THE TEAM MAINTAINS, LEADERSHIP MEANS INFLUENCING AND MOBILIZING THE COMMUNITY TO FACE PROBLEMS. IN THIS EVALUATION, SUCH PROBLEMS INCLUDE THE FAILURE OF NSV TO TAKE OFF, UNNECESSARY PAIN DURING MINILAPAROTOMY WITH LOCAL ANESTHESIA, AND TARGET SETTING. GRAPHIC 2 ILLUSTRATES SUCH A PARADIGM OF LEADERSHIP. THE RESULTS FOR THE FOLLOW-ON COOPERATIVE AGREEMENT HAVE BEEN FORMULATED BY AVSC AND THE TEAM TO ENABLE AVSC TO PLAY JUST SUCH A LEADERSHIP ROLE.

RECOMMENDATION

THIS FINAL RECOMMENDATION IS THE MOST IMPORTANT OF THE REPORT.

20. THE MANDATE FOR AVSC IN THE FOLLOW-ON COOPERATIVE AGREEMENT SHOULD HAVE, AS ITS CORE, PROMOTING ACCESS TO AND QUALITY OF LONG-TERM AND PERMANENT METHODS OF CONTRACEPTION. (RECOMMENDATION #1 IN MAJOR CONCLUSIONS AND RECOMMENDATIONS)

GRAPHIC 2 (LEADERSHIP GRAPHIC)

THE MANDATE OF "PROMOTING ACCESS TO AND QUALITY OF LONG-TERM AND PERMANENT METHODS OF CONTRACEPTION" APPLIES MOST SPECIFICALLY TO CORE FUNDING. IN CONTRAST, FIELD SUPPORT FUNDED RESULTS, TO BE DETERMINED BY MISSIONS IN COLLABORATION WITH AVSC AND HOST-COUNTRY INSTITUTIONS, MIGHT BE BROADER. THE FIRST SIX OF THE FOLLOWING RESULTS APPLY TO AVSC COMPREHENSIVE COUNTRY PROGRAMS, THAT IS TO COUNTRY PROGRAMS WHERE AVSC IS WORKING IN COMPREHENSIVE PARTNERSHIP WITH THE MAJOR SERVICE DELIVERY HEALTH INSTITUTIONS? RESULTING IN SIGNIFICANT INCREASE IN ACCESS TO QUALITY RH SERVICES.

1 IN COUNTIES WITH SIGNIFICANT AVSC/COOPERATIVE AGREEMENT INVESTMENT, WOMEN AND MEN ARE ABLE TO ACHIEVE, WITH GREATER SUCCESS, THEIR REPRODUCTIVE INTENT TO SPACE AND LIMIT FAMILY SIZE USING CLINICAL OR SURGICAL METHODS.

INDICATORS:

- THE PERCENTAGE DISTRIBUTION OF CONTRACEPTIVE USERS BY METHODS
- THE PERCENTAGE DISTRIBUTION OF VARIOUS LONG-TERM AND PERMANENT METHODS WITHIN A NATIONAL PROGRAM

RATIONALE: LIMITING FAMILY SIZE THROUGH LONG-TERM AND PERMANENT METHODS IS THE DESIRE OF MILLIONS OF WOMEN AND MEN AROUND THE WORLD. THIS DESIRE REMAINS UNMET DUE TO WOULD NEGATIVE POLICIES AND LACK OF, OR INACCESSIBILITY OF, HIGH-QUALITY CLINICAL FACILITIES. AVSC IS UNIQUELY EQUIPPED TO ADDRESS THIS NEED. THIS RESULT IDENTIFIES AVSC'S EFFECT AT THE IMPACT LEVEL.

2 IN SELECTED HEALTH FACILITIES WHERE AVSC HAS INVESTED SIGNIFICANT RESOURCES IN DEVELOPING CAPACITY OF THOSE INSTITUTIONS TO TREAT POSTABORTION COMPLICATIONS AND TO PROVIDE COUNSELING/EDUCATION AND FOLLOW-UP TO THOSE CLIENTS, DEATHS FROM SEPTIC ABORTION AND HEMORRHAGE HAVE DECREASED.

INDICATORS:

- INSTITUTIONAL CASE FATALITY RATE RELATED TO POSTABORTION COMPLICATIONS (NUMBER OF WOMEN WHO DIE FROM POSTABORTION COMPLICATIONS RELATIVE TO THE NUMBER REPORTING TO THE HOSPITAL WITH SUCH COMPLICATIONS)

- ? PERCENT OF POSTABORTION WOMEN WHO CHOSE TO LEAVE WITH A FAMILY PLANNING METHOD

RATIONALE: THE TEAM RECOMMENDS SPECIFICALLY ADDING PAC TO AVSC'S CORE ACTIVITIES BECAUSE, AS DISCUSSED IN CHAPTER 4, IT IS A HIGH-IMPACT SERVICE THAT CAN BE EASILY ADDED TO AVSC'S CLINICAL ACTIVITIES, WITH RELATIVELY SMALL INCREMENTAL COSTS.

3 IN COUNTIES WITH SIGNIFICANT AVSC/COOPERATIVE AGREEMENT INVESTMENT, THERE IS INCREASED AVAILABILITY AND ACCESS TO HIGH-QUALITY CLINICAL FAMILY PLANNING SERVICES (LONG-ACTING AND PERMANENT METHODS) AND TO OTHER CLOSELY RELATED REPRODUCTIVE HEALTH SERVICES, PARTICULARLY POSTABORTION CARE.

INDICATORS:

- PERCENTAGE OF AVSC-FACILITATED SERVICE DELIVERY POINTS (SDP) OFFERING LONG-ACTING AND PERMANENT METHODS ACCORDING TO NATIONAL STANDARDS (COUNSELING, INFECTION PREVENTION, ETC.) AND OFFERING REFERRAL FOR OTHER REPRODUCTIVE HEALTH SERVICES AS APPROPRIATE AND FEASIBLE.
- PERCENTAGE OF AVSC-FACILITATED SDPS WHERE PROVIDERS COMPLY WITH STANDARDS/PROTOCOLS FOR CLINICAL FAMILY PLANNING SERVICES AND OTHER CLOSELY RELATED REPRODUCTIVE HEALTH SERVICES (FOR WHICH AVSC HAS PROVIDED TECHNICAL ASSISTANCE).
- PERCENTAGE OF AVSC-FACILITATED SDPS PROVIDING PAC SERVICES (TREATMENT OF COMPLICATIONS, PROVISION OF COUNSELING AND FP, REFERRAL FOR OTHER FP AND RH SERVICES).
- PERCENTAGE OF AVSC-FACILITATED SDPS PROVIDING SERVICES TO SPECIAL POPULATIONS SUCH AS MEN, POSTPARTUM WOMEN, OR ADOLESCENTS.

RATIONALE: HIGH QUALITY IS FUNDAMENTAL. THIS RESULT STRESSES THAT HIGH QUALITY MUST GO TOGETHER WITH INCREASED AVAILABILITY AND ACCESS. THE EVALUATION TEAM SUGGESTS ADDING "SELECTED, CLOSELY RELATED OTHER REPRODUCTIVE HEALTH SERVICES" TO CLINICAL FAMILY PLANNING SERVICES TO PROVIDE A WINDOW OF OPPORTUNITY FOR USAID IF AND WHEN IT SHOULD NEED AVSC'S ASSISTANCE IN OTHER AREAS.

4 AT AVSC-FACILITATED INSTITUTIONS, THERE IS INCREASED CLIENT SATISFACTION ON THE PART OF THOSE WOMEN AND MEN WHO CHOSE TO USE LONG-ACTING AND PERMANENT METHODS OF FAMILY PLANNING AND AMONG THOSE WHO CHOSE TO AVAIL THEMSELVES OF OTHER CLOSELY RELATED REPRODUCTIVE HEALTH SERVICES.

INDICATOR:

- AT AVSC-FACILITATED INSTITUTIONS, PERCENT OF CLIENTS RECEIVING CLINICAL RH SERVICES WHO REPORT A HIGH LEVEL OF SATISFACTION WITH THOSE SERVICES (LONG-ACTING AND PERMANENT METHODS OF FAMILY PLANNING AND PAC).

RATIONALE: CUSTOMER SATISFACTION IS ONE OF USAID'S FOUR CORE VALUES AND ONE RESULT ON WHICH MISSIONS ARE OBLIGED TO REPORT REGULARLY. ALTHOUGH IN MANY COUNTRIES WITH RELATIVELY LIMITED AVSC/COOPERATIVE AGREEMENT FUNDING IT WOULD NOT BE FEASIBLE OR APPROPRIATE FOR AVSC TO CORRELATE THEIR INPUTS WITH AN OUTPUT OF CUSTOMER SATISFACTION, IN COUNTRIES WITH COMPREHENSIVE AVSC PROGRAMS IT IS ESSENTIAL THAT AVSC DO SO.

5 WITHIN SELECTED (HIGH INVESTMENT) AVSC-FACILITATED, HOST-COUNTRY INSTITUTIONS, BEHAVIORAL CHANGE ON THE PART OF RH PROVIDERS HAS RESULTED IN IMPROVED CLIENT FOCUS AND CUSTOMER SATISFACTION.

INDICATOR:

- PERCENT OF ALL PROVIDERS AND STAFF WITH DIRECT CONTACT WITH RH CLIENTS WHO SHOW RESPECT FOR CLIENTS DURING THESE INTERACTIONS.

RATIONALE: AVSC WORKS TO MEET THE NEEDS OF PROVIDERS (FOR SUPERVISION, TRAINING, SUPPLIES, ETC.) SO THAT THEY IN TURN CAN MEET THE NEEDS OF CLIENTS. THE OBJECTIVE IS TO SERVE CLIENTS BETTER.

6 THERE IS, AMONG AVSC-FACILITATED, HOST-COUNTRY INSTITUTIONS, AN INCREASED ORGANIZATIONAL CAPACITY FOR PLANNING, MANAGING, AND EVALUATING CLINIC-BASED FAMILY PLANNING AND OTHER CLOSELY RELATED REPRODUCTIVE HEALTH SERVICES.

INDICATORS:

- PERCENT OF AVSC-FACILITATED INSTITUTIONS THAT HAVE THE INDEPENDENT CAPACITY TO ROUTINELY AND SUCCESSFULLY MEDICALLY MONITOR CLINICAL FAMILY AND OTHER CLOSELY RELATED REPRODUCTIVE HEALTH SERVICES.

- PERCENT OF AVSC-FACILITATED INSTITUTIONS THAT HAVE THE INDEPENDENT CAPACITY TO ROUTINELY AND SUCCESSFULLY ASSURE INFORMED CHOICE FOR STERILIZATION AND OTHER FAMILY PLANNING SERVICES.

- PERCENT OF AVSC-FACILITATED INSTITUTIONS THAT HAVE THE INDEPENDENT CAPACITY TO ROUTINELY AND SUCCESSFULLY ASSURE AND IMPROVE THE QUALITY OF CLINICAL FAMILY PLANNING SERVICES.[1]

- PERCENT OF AVSC-FACILITATED INSTITUTIONS THAT HAVE FUNCTIONAL TRAINING SYSTEMS TO ROUTINELY IDENTIFY, ASSESS, AND MEET PROVIDER NEEDS FOR TRAINING FOR SERVICE DELIVERY IN STERILIZATION, AND/OR OTHER CLINIC-BASED FAMILY PLANNING METHODS, PAC AND INFORMED CHOICE, AND OTHER CLOSELY RELATED RH SERVICES, AS APPROPRIATE IN THE NATIONAL PROGRAM.

RATIONALE: AVSC INPUTS IN TECHNICAL ASSISTANCE, TRAINING, SUPERVISION, AND QUALITY MANAGEMENT ARE DIRECTED TO INCREASE THE CAPACITY OF HOST-COUNTRY INSTITUTIONS TO PLAN, MANAGE, AND EVALUATE HIGH-QUALITY CLINICAL SERVICES THEMSELVES. THIS RESULT AND ACCOMPANYING INDICATORS PLACE AVSC'S EFFORTS AT THE OUTPUT RATHER THAN THE INPUT LEVEL.

7 IN COUNTRIES WITH RELATIVELY LIMITED AVSC/COOPERATIVE AGREEMENT FUNDS (IN CONTRAST TO COMPREHENSIVE PROGRAMS), AVSC PROVIDED INPUTS TO PROMOTE THE NATIONAL RH PROGRAM IN RESPONSE TO USAID'S REQUESTS.

INDICATORS:

- NUMBER OF COUNTRIES IN WHICH AVSC PROVIDED CONCRETE, RELATIVELY LIMITED SERVICES (SUCH AS A NEEDS ASSESSMENT OR TRAINING) FOR WHICH IT IS NOT FEASIBLE OR APPROPRIATE TO MONITOR AND EVALUATE AT THE IMPACT LEVEL.

- MISSION SATISFACTION WITH THIS AVSC PERFORMANCE.

[14] There should be careful, systematic testing and evaluation of HRM tools/methodologies (facilitative supervision, OJT, COPE, wide-scale iteration of counseling, and clinical TOT in the public sector) before system-wide or institution-wide scale-up.

- NUMBER OF COUNTRIES IN WHICH MISSIONS PROVIDED EVEN LIMITED FIELD SUPPORT FUNDS FOR AVSC'S EFFORTS TO PROMOTE ONE OR MORE ASPECTS OF THE NATIONAL RH PROGRAM.

- PERCENT OF COUNTRIES IN WHICH THE AVSC COUNTRY WORKPLAN WAS ACCOMPLISHED.

RATIONALE: IN COMPREHENSIVE COUNTRY PROGRAMS IT WILL BE POSSIBLE, WITH ADDITIONAL EFFORT, FOR AVSC TO PLAN RESULTS AND MEASURE CHANGE AT THE OUTPUT AND IMPACT LEVEL. IN MANY OTHER COUNTRIES WHERE AVSC CARRIES OUT SMALL DISCRETE ACTIVITIES, RESULTS AND INDICATORS WILL BE AT THE PROCESS LEVEL. THIS RESULT IS MEANT TO CAPTURE SUCH LIMITED PROGRAM ACTIVITIES.

8 AS A RESULT OF AVSC'S VISION AND LEADERSHIP, THERE HAS BEEN A CHANGE AT THE GLOBAL AND/OR NATIONAL LEVEL, IN CLINICAL RH TECHNIQUES TOWARD SAFER AND MORE EFFECTIVE RH SERVICES.

INDICATORS:

- NUMBER OF CLINICAL AND/OR SURGICAL EXPLORATORY STUDIES DONE TO EXPAND, SIMPLIFY, AND MAKE SAFER PERMANENT METHODS OF CONTRACEPTION THAT HAVE BEEN STUDIED WITHIN THE RH COMMUNITY AND THAT HAVE LED TO CHANGES IN TECHNIQUE AT THE GLOBAL OR COUNTRY LEVEL.

- NUMBER OF CLINICAL AND/OR SURGICAL EXPLORATORY STUDIES FOCUSED ON PROMISING RH INNOVATIONS THAT HAVE BEEN STUDIED WITHIN THE RH COMMUNITY AND THAT HAVE LED TO CHANGES IN TECHNIQUE AT THE GLOBAL OR COUNTRY LEVEL.

RATIONALE: OVER THE PAST DECADES, AVSC HAS HAD THE VISION TO SEE AND IMAGINE NEW AND IMPROVED LONG-TERM FAMILY PLANNING CLINICAL/SURGICAL TECHNIQUES AND PROCEDURES. AVSC THEN MOBILIZED GROUP RESOURCES (USAID AND PROVIDERS) TO EXPAND THE NEW TECHNIQUES. THE RESULT WAS CHANGE: THE DEVELOPMENT AND INSTITUTIONALIZATION OF MINILAPAROTOMY WITH LOCAL ANESTHESIA IN MANY DEVELOPING COUNTRIES, THE ACCEPTANCE OF NSV THROUGHOUT THE WORLD, AND THE REVIVAL OF PPIUD. SUCH LEADERSHIP CONTINUES TO BE NEEDED.

9 AS A RESULT OF AVSC'S VISION AND LEADERSHIP, ADDITIONAL FUNDS (BEYOND THOSE PROVIDED TO AVSC BY USAID IN THIS COOPERATIVE AGREEMENT) HAVE BEEN INVESTED IN NEW CLINICAL FAMILY PLANNING AND OTHER CLOSELY RELATED RH SERVICES, TECHNIQUES, OR PRODUCTS THAT MEET CLIENT NEEDS FOR SAFE AND EFFECTIVE SERVICE DELIVERY.

INDICATOR:

- LEVEL OF FUNDING INVESTED IN EXPANDING THOSE NEW CLINICAL FAMILY PLANNING AND OTHER CLOSELY RELATED RH SERVICES, TECHNIQUES, OR PRODUCTS.

RATIONALE: THE NEED FOR AVSC'S CONTINUED LEADERSHIP WAS EXPRESSED IN RESULT 8. THIS LEADERSHIP SHOULD LEAD TO BOTH SAFER AND MORE EFFECTIVE SERVICES AND TO ADDITIONAL FUNDS, BEYOND THOSE PROVIDED TO AVSC BY USAID IN THIS COOPERATIVE AGREEMENT.

10 AS A RESULT OF AVSC'S VISION AND LEADERSHIP, THERE IS A SHIFT TOWARD GREATER USE OF VASECTOMY.

INDICATOR:

- CPR FOR VASECTOMY IN SELECTED COUNTRIES

RATIONALE: VASECTOMY IS A SAFER AND CHEAPER METHOD OF PERMANENT CONTRACEPTION THAN FEMALE STERILIZATION FOR FAMILIES THAT WISH TO LIMIT CHILDBEARING. IN THE POST-CAIRO ERA, IT IS APPROPRIATE TO FOCUS ON MEN AS FULL PARTNERS IN CONTRACEPTION.

APPENDICES

APPENDIX A

Scope of Work

I. Program Information

Project Name and Number	Program for Voluntary Surgical Contraception (936-3068)
Cooperative Agreement No.	CCP-3068-A-00-3017-00
Agreement Value	$118,000,000 (8/23/93 to 8/23/98)
Obligation to Date	$72,094,637 (12/31/96)

II. Background

A. AVSC International

AVSC International (formerly the Association for Voluntary Surgical Contraception) is a non-profit organization that works to improve reproductive health services world wide. Established in 1943, AVSC was founded in order to make quality voluntary sterilization services available and accessible throughout the world, and for ensuring informed choice in decision-making for voluntary sterilization. In the 1980s AVSC broadened its focus to encompass the full range of long-term family planning methods.

The purpose of the AVSC Cooperative Agreement is to introduce and expand voluntary surgical contraception and other long-term methods. The key elements of the cooperative agreement include the following: 1) medical quality assurance, 2) voluntarism and informed choice, 3) client centered systems, 4) service based training, 5) vasectomy and male involvement in family planning, 6) postpartum and post-abortion family planning services, 7) social marketing, 8) sustainable and cost effective services, and 9) evaluation and research.

Since the authorization of the Cooperative Agreement, AVSC, as well as USAID, has undergone major change in its approach to their respective goals and objectives. Four important changes have occurred which have impacted on the program:

B. Key Factors Affecting the Cooperative Agreement

1. The 1993 Government Performance and Results Act

This requires all Government agencies to develop strategic plans including mission statements, goals and objectives. Although all USAID Missions had such plans they did not exist for all of USAID's central programs.

The outcomes Government Performance and Results Act led USAID to begin developing a new strategic plan. The outcomes of Cairo contributed to the shaping of the new strategic plan and results framework for the Center for Population, Health, and Nutrition. The strategic plan includes four strategic objectives (SO):

1. Increased use of voluntary practices by men and women that contribute to fertility reduction.

2. Increased use of safe pregnancy, women's nutrition, family planning, and other key reproductive health interventions.

3. Increased use of key child health and nutrition interventions; and

4. Increased use of proven interventions to reduce HIV/STD transmission.

The work of the Family Planning Services Division of the Office of Population, Health and Nutrition primarily focuses on Strategic Objective 1, although programs such as AVSC, often contributed to other strategic objectives. Since the adoption of the strategic plan and the results framework, AVSC's activities have focused primarily on SO 1 and to a lesser extent on SO 4. AVSC has summarized their areas of involvement under SO 1 in the attached table. AVSC's recent annual evaluation report (1995-96) and most recent workplan (Fiscal 1997-98) include a description of the contribution of their activities to the USAID SOs.

2. The 1994 International Conference on Population and Development (ICPD)

This meeting in Cairo brought together government and non-governmental officials to forge a new paradigm and consensus for a broader reproductive health framework. AVSC contributed to the development of this new consensus and since Cairo, AVSC has been working to integrate the principles and recommendations contained in the ICPD Programme of Action into all of its activities.

3. USAID Field Support Funds

Another significant change was the shift in the funding mechanism from central, core funds to field support funds. This shift in funding mechanism required AVSC to be more flexible and pro-active in meeting the needs of USAID Missions. At the same time, AVSC has broadened its funding base. AVSC uses its USAID funds to leverage support from other donors. AVSC works in 14 of the 15 USAID Joint Programming Countries (all but Morocco) and 18 of the 28 Joint Planning Countries. In FY 1997/98 AVSC is active in nearly 40 USAID supported programs

In addition to their work at the country level, AVSC also strategically targets resources to work at the global level. AVSC uses USAID global "core" funds for these programs that are of special concern in the reproductive health field. Global programs encompass activities conducted for the general advancement of reproductive health including family planning.

4. Restructuring at AVSC

In late 1995, the AVSC Board of Directors selected former Medical Director, Amy Pollack to succeeded Hugo Hoogenboom as President.

During 1996 AVSC undertook a comprehensive internal review of its processes and organization in response to several external and internal forces. As a result, AVSC set organizational goals for achieving its mission, and realigned the organization to support and carry out these goals. In addition, AVSC redesigned several processes, to better and more flexibly deploy staff and other resources in accordance with program needs and priorities. Multidisciplanary teams (contributing to goals) have replaced functional departments (organized by division) as the basic work units to which staff are assigned so that AVSC can better and more effectively respond to changing customer needs and opportunities on a decentralized basis.

III. Purpose of Evaluation

This evaluation will provide important information for the development of a follow-on program. One half of the evaluation exercise should focus on past accomplishments and one half on future needs of USAID and new and emerging issues. The objectives for the evaluation are:

1. To assess the extent to which AVSC has accomplished the purposes and objectives as set forth in the Cooperative Agreement.

2. To assess the effectiveness and efficiency of AVSC's organizational and management structure.

3. To assess how well AVSC's program has advanced the strategic objectives of selected USAID Missions and the G/PHN strategic objectives and results framework.

4. To recommend improvements to the existing program.

5. To identify other priority needs in reproductive health that USAID should address and identify those that AVSC is particularly suited to meet. Suggest approaches for meeting those needs.

The evaluation will result in the following concrete outcomes:

? recommendations on how to revise or realign the Cooperative Agreement?s purpose and objectives for the remainder of this agreement and the future one.

? recommendations for new intermediate results and corresponding indicators to be used in a revised program description.

? recommendations for improving USAID and AVSC?s partnership, in the areas of coordination and communication at the G/PHN and USAID Mission level, and with other cooperating agencies.

IV. Statement of Work

The scope of work is divided into two sections; one section contains questions for the external evaluation team and the other contains questions that AVSC will address in a written background document.

A. External Evaluation Team

While giving special attention to the questions outline below, the evaluation report should analyze the extent to which AVSC has accomplished the purpose and objectives of the Cooperative Agreement and should address future issues and challenges. The questions are organized around three issues that require the input of an external evaluation team:

1. How well does AVSC manage for desired results through a) its programming approaches and strategies and b) the management and organization of the cooperative agreement?

Programming Approaches:

a. How does AVSC establish its priorities for country and global programs, addressing the following three areas:

(1) Expanding access while maintaining quality;

(2) Integrating other reproductive health activities into family planning; and

(3) Budget and USAID Mission priorities.

b. At the county level, what are the opportunities and constraints for AVSC to work in partnership with counterparts to build sustainable reproductive health services? Where have these efforts been successful and what are the challenges for future work?

c. How well do AVSC?s quality improvement approaches contribute to USAID?s results of new and improved technologies and increased access to quality reproductive health services and information?

d. What is the appropriate role of training in AVSC?s quality improvement and access efforts, keeping in mind opportunities and constraints for collaborating with other training CAs.

e. Does research play an appropriate role in AVSC?s overall strategy and programming? What are the priorities for the future research agenda?

f. Given AVSC?s service delivery ?mandate,? but its extensive involvement in training and research (as per questions d and e above), to what extent does AVSC collaborate with other CAs involved in training and research, and how can this collaboration be improved? (Pay particular attention to JHPIEGO.)

g. How has and how can AVSC advance knowledge in the field of reproductive health? What leadership role does or can AVSC play? How does and how can AVSC work with other CA?s and organizations?

Cooperative Agreement Organization and Management:

a. How has AVSC changed organizationally to respond to the organizational, programmatic and funding changes in USAID?

b. Is AVSC considered an effective and reliable partner by G/HPN and the USAID Missions?

c. How do AVSC's field offices relate to headquarters? To what degree have these offices been delegated authority to make program and financial decisions?

d. Do Missions and G/PHN consider the AVSC program to be an important contributor to achieving their strategic objectives? In what programmatic areas is AVSC called on to contribute? How is AVSC's niche characterized by the Missions and by G/PHN?

e. What are the advantages and disadvantages (if any) of field-based offices and country-based staff?

f. Does USAID receive the financial information it requires to manage the cooperative agreement? How can it be improved?

g. How well has USAID managed the project? Comment on the relationship with the CTO; Office of Population; PHN Center, Office of Procurement.

2. To what extent can AVSC demonstrate its contributions to the USAID results framework?

a. How does AVSC track its programs globally? How effective is this system?

b. How effective are AVSC?s evaluation strategies? How can they be improved?

c. Should the CA?s logical framework be redesigned in light of USAID?s strategic results framework? If so, what are the **most important** (not to exceed 10) results AVSC should track and report on?

3. What should be AVSC's mandate for USAID Funding Considering the Following:

a. AVSC?s comparative advantage

b. AVSC's experience in clinic-based family planning

c. The need to meet both global and country-level objectives and results

d. USAID priorities

e. Limits on AVSC resources

What should be the program priorities under the new cooperative agreement?

B. AVSC

To complete the evaluation, the team will need background information and the answers to the questions below. AVSC will provide the answers to the these questions by highlighting available empirical information, documenting existing information and where necessary preparing the information necessary for the teams review.

1. Quality Improvement and Quality Assurance:

a. What are AVSC's approaches to quality assurance?

b. Have AVSC's efforts in medical quality assurance led to development of institutional and national guidelines for reproductive health services? Where? Are they followed and how is the impact evaluated?

2. Training Issues

a. Has AVSC developed or adapted a model or particular approach to service-based training that is cost-effective, sustainable and replicable?

b. To what extent has AVSC linked its clinical/medical training to reproductive health (maternity, STD, post-abortion care) and other aspects of service delivery such as counseling, quality improvement and quality assurance, clinic management?

c. Is AVSC effective in identifying appropriate personnel for training and how well do they follow-up? Is the impact of training being evaluated and how? (eg. Does infection prevention training result in fewer post-op infections.)

3. Meeting Clients' Rights and Needs

a. What is AVSC's approach to addressing the reproductive health needs of clients? Is it effective and sustainable?

b. What evidence is there that the institutions supported by AVSC are complying with the Standard Provisions concerning voluntarism and informed consent?

c. What are the emerging critical issues in the area of informed choice that AVSC should address in the future? Can AVSC's experience and activities in client-centered approaches and informed choice inform AVSC's expanded role in other aspects of reproductive health?

4. Special Populations - Men, Post-abortion, Post-partum, other groups

a. Men

(1) Has AVSC been successful in increasing male involvement in reproductive health? What is the impact? Where has AVSC been most successful in increasing male involvement?

(2) Has AVSC developed specific approaches or strategies that are replicable and sustainable.

(3) How is AVSC collaborating with other CAs in male involvement activities? Can AVSC play a unique role in furthering attention to male involvement strategies? In what ways are AVSC's activities similar or different from other CAs.

b. Post-partum Clients

(1) What has AVSC done to increase the availability of family planning and other reproductive health services to postpartum clients? Have these efforts been institutionalized, and if so, where?

(2) Does AVSC have specific approaches for increasing services to postpartum clients that are successful and replicable?

c. Post-abortion

(1) Has AVSC been successful in increasing access to post-abortion care? Where?

(2) Has AVSC developed specific approaches to increase post-abortion care that are successful and replicable.? What unique role can AVSC play to further attention to post-abortion care?

(3) How has AVSC collaborated with other CA's in post-abortion care?

d. Other Groups

Describe AVSC's experience with other populations (adolescents and refugees.) Should they be continued, expanded?

5. Policy Changes

Has AVSC been instrumental in effecting change in national policies, paying particular attention to the following areas:

a. Sterilization - availability, age, parity, spousal consent, etc.

b. Post-abortion care

6. Leveraging of Other Resources

a. How has AVSC used USAID funding to leverage funding from other donors and private sources? How successful have they been in these endeavors? Are there other sources that AVSC should pursue?

b. Have USAID contacts with other donors and foundations (both in the US and overseas) assisted AVSC to leverage other resources? Can USAID do more in this area?

7. Management Issues

AVSC will provide the evaluators with details on their restructuring, decentralization, delegations of authority to the field and staffing information.

V. Materials and Procedures

A. Data Sources

The evaluation team will review all project documentation including but not limited to the following: AVSC's Cooperative Agreement (CA), workplans, trip reports, financial reports, AVSC's internal evaluations. The team should also review key publications produced as part of the cooperative agreement such as the COPE manual, medical monitoring tools, training manuals, curricula. In addition to the documents pertaining to this cooperative agreement, the team members should also review program documentation on the bilateral, USAID cooperative agreements in Ghana and Bangladesh and programs funded by other donors and private sources. A review of these documents is recommended because they may give the team a broader, and more forward-looking view of AVSC's overall capabilities.
AVSC will prepare background materials for the team.

B. Methods of Data Collection

1. Interviews

The team will interview AVSC staff at headquarters, regional and country offices, other cooperating agencies working with AVSC, USAID/Washington personnel and Mission personnel and personnel of institutions that AVSC is working with overseas.

FPSD will send an e-mail to the appropriate field Missions for input into this evaluation. The Missions will be asked to provide information about AVSC's activities, their contribution to Mission strategic plans and about the future role of AVSC in specific countries. Based upon review of Mission responses, the team may wish to follow-up on these responses with interviews (telephone or e-mail) of Mission staff in various countries.

2. Field Visits

After reviewing documents, the evaluation team will visit India, Nepal, and Kenya. In addition, using internal AVSC evaluation materials and interviews, the teams will describe progress in selected priority countries not visited. The rationale for country selection is as follows:

a. India. Long-term USAID involvement, size of program, multiple CA involvement, and quality of care/informed consent issues. Program contains all key elements of the AVSC program.
b. Nepal. Similar to many issues above plus, development and institutionalization of standards including outreach program. Program contains all key elements of the AVSC program.

c. Kenya. Long-term USAID involvement, male-involvement, multiple CAs, large regional

office. Program contains all key elements of the AVSC program.

C. Duration and Timing

The evaluation will begin early October 1997. Approximately 8 weeks will be required for data collection and drafting the report.

The schedule is as follows:

Week 1: (4 days) Washington
Week 2: (4days) New York
Week 3: Field Visits
Week 4: Field Visits
Week 5: Field Visits
Week 6: NY and Washington de-briefings with summary recommendations.
Week 8: First draft received at POPTECH and copies distribute to team members, USAID CTO, AVSC and assignment manager.
Week 9: Comments received by POPTECH and sent to team-leader
Week 11: Second draft received
Week 13: POPTECH edits and sends clearance draft to USAID CTO for approval
Week 15: USAID gives final clearance or returns with minor changes.
Week 17: POPTECH makes final changes and distributes.

E. Team Composition

The team will consist of 3 members plus a USAID intern if available.

1. One OB/GYN with extensive experience in family planning and reproductive health with specific skills in surgical contraception including non-scalpel vasectomy, tubal ligation (including minilaporatomy), infection prevention, quality assurance, and post-abortion care

   He/she will review counseling, medical procedures including surgery, and training sessions if possible.

2. Two experts with broad experience in family planning program development, implementation, training and evaluation. At least one expert with USAID results framework and design experience.

3. Intern. USAID will provide an intern to assist with the evaluation. The intern will assist with the writing of reports during the field visits and selected sections upon return to the US. Direction will be provided by the team leader.

IV. FUNDING AND LOGISTICAL SUPPORT

All funding and logistic support for the AVSC evaluation will be provided through the Population Technical Assistance Project (POPTECH) except that USAID may provide an intern to assist with he evaluation. Activities that will be covered include recruitment of the evaluation team, payment of the evaluation team, payment of the evaluation team for a six day work week, support for all expenses related to the evaluation, logistical support and publication of the draft and final report.

AVSC will arrange in-country transportation and schedule meetings as requested. AVSC will make a country or regional representative available to the team to answer questions as appropriate.

FPSD will e-mail the questionnaire to the USAID Missions and provide the responses to POPTECH.

Strategic Objective #1: Increased use of voluntary practices that contribute to fertility reduction

	Quality Improve.	Clients ' Rights and Needs	Increasing Access	Inst. Capacity and Sustainability	Special Pops.	Global Program Strategies	Eval. & Research
Result 1.1 New and improved technologies and approaches for family planning	X	X	X	X	X	X	X
Result 1.2 Improved policy environment and increased global resources for family planning programs	X		X	X	X	X	X

Result 1.3 Enhanced capacity for public, private, NGO and community based organizations to design, implement and evaluate sustainable family planning programs.	X		X	X	X	X	X
Result 1.4 Increase access to quality of, cost effectiveness of and motivation for use of family planning, breastfeeding and selected reproductive health information and services.	X	X	X	X	X	X	X

APPENDIX B

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APPENDIX C

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APPENDIX D

AVSC Evaluation Questionnaire

Mission:_____

PHN/POP/FPSD is planning the final external evaluation of the Office of Population's Cooperative agreement with AVSC International. We would like your assistance with this evaluation.

An independent, three-member team will begin the evaluation on October 6, 1997. The team will carry out site visits to Kenya, Nepal and India. The team will conduct interviews with various USAID/W staff and Missions, review project documents/reports, and visit AVSC headquarters as the basis for the evaluation.

Approximately fifty percent of the effort will be devoted to providing recommendations for a follow-on, five-year cooperative agreement to begin in August 1998 when the present cooperative
agreement ends. Since the team will be able to visit only three countries, field comments are very important to both USAID and AVSC in preparation of the new program.

We would like to have your responses by September 15, 1997.

Team members may wish to make follow-up phone calls either to clarify your responses or to get original data.

Background

The purpose of the current AVSC Cooperative Agreement is to introduce and expand voluntary surgical contraception and other long-term methods. The key elements of the cooperative agreement include the following: 1) medical quality assurance, 2) voluntarism and informed choice, 3) client centered systems, 4) service based training, 5) vasectomy and male involvement in family planning, 6) postpartum and post-abortion family planning services, 7) social marketing, 8) sustainable and cost effective services, and 9) evaluation and research. Not all these elements are included in every country program, especially smaller programs.

Questions

1. Does your Mission consider the AVSC program to be an important contributor to achieving your strategic objectives? In what specific area(s)is AVSC called on to contribute?

2. What has been AVSC's impact on the availability and quality of family planning/reproductive health training and service delivery?

3. Have AVSC's efforts in medical quality assurance led to development of institutional and national guidelines for reproductive health services? Are they followed and is the impact evaluated?

4. What impact has AVSC had on national reproductive health guidelines, policy and regulatory practices? Should there be more concerted efforts in these areas?

5. Does AVSC pay enough attention to sustainability when working with host-country institutions? Will AVSC's program be able to carry on without donor-funded inputs (technical assistance, salary supplements, replacement equipment, etc) once AVSC ceases to fund the program. Or, does the mission view that as a necessary concern of AVSC?

6. Is AVSC effective in identifying appropriate personnel for training and how well do they follow-up? Is the impact of training being evaluated and how? (eg. Does infection prevention training result in fewer post-op infections.)

7. Please comment on communication between AVSC headquarters, the Missions, AVSC resident representatives and host countries. In your opinion, have country and regional offices been delegated sufficient authority to make program and financial decisions?

8. Is there adequate collaboration and coordination with other agencies? Do these efforts need to be improved?

9. Does USAID receive the financial information it requires to manage the cooperative agreement? How can it be improved?

10. What recommendations do you have for a future AVSC cooperative agreement, for example:

> -- What should AVSC do differently in the future to enhance sustainability, capacity building, and institutionalization?

-- Are there specific areas of reproductive health training that AVSC should address that it is not addressing now? Are the gaps in provider training that neither AVSC nor other CAs (PRIME/INTRAH, Pathfinder, JHPIEGO and SEATS) are addressing?

-- Should AVSC broaden its mandate to include other areas of reproductive health?

Please provide any other comments you would like to share with the AVSC evaluation team.

Thank you very much for your assistance with this evaluation.